Rose Isabel Williams Mental Health Reform Act of 2020

Quarterly Status Report
October 1, 2021 – December 31, 2021

MS Department of Finance and Administration
Office of the Coordinator of Mental Health Accessibility

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Abstract

This report is submitted pursuant to MCA § 41-20-5(h) of the *Rose Isabel Williams Mental Health Reform Act of 2020* which implemented a comprehensive review and report on Mississippi's mental health system to assess the structure, funding, adequacy, delivery, and availability of services throughout the State. This quarterly report covers the period of October 1, 2021, through December 31, 2021. Assessments performed during this period include reviews of various individual regional mental health centers (Community Mental Health Centers or CMHCs) that are under the control of regional commissions established by "the boards of supervisors of the various counties in the region." MCA § 41-19-33.

The report builds on a model introduced in OCMHA's report for the second quarter and offers additional detail on a new model that creates Certified Community Behavioral Health Clinics (CCBHC). This model has been initiated in a number of states around the nation and may have merit for application in Mississippi. The next topic is regarding Commitments for Behavioral Health Disorders by county and region. Information was gathered from each chancery clerk in every county of Mississippi and comparisons are made accordingly. Other topics addressed in this report are Crisis Intervention Teams (CIT) which includes a recommendation and Alternative Living Arrangements for people with Serious Mental Illness which includes a recommendation.

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Certified Community Behavioral Health Center (CCBHC) Model

Similar to national trends, there are current challenges facing behavioral health providers in Mississippi and include:

- Increased demand for services
- Suicide
- Accidental overdose related to opioid and stimulant use disorders
- Reductions in inpatient psychiatric hospital resources
- Workforce shortages
- Financial instability or reduced ability to expand staff and services

The National Council of Mental Wellbeing reports that CMHCs must earn a surplus of 15% or more to balance a budget and more than 75% of the state association members lost money on psychiatric services alone (The Psychiatric Shortage: Causes and Solution, 2018). One option that appears to have merit and has been used in at least 42 other states is the CCBHC model. CCBHCs are designed to increase access to quality care and reduce suicides, overdose deaths, barriers to timely access to addiction and mental health treatment, inadequate care for veterans, and use of overburdened jails and emergency departments. Data from the CCBHC model demonstrates a payment structure that may be sustainable, offering sufficient financial support while prescribing specific programmatic requirements (The National Council CCBHC Success Center, 2021).

The model offers no changes in who is eligible for Medicaid. A new provider type can be made available through Medicaid allowing CCBHCs to receive an enhanced rate based on anticipated costs of expanding services. CCBHCs must provide care regardless of the ability to pay and regardless of catchment or service area. The model allows for outreach to engage persons who may already meet criteria for enrollment in Medicaid and have not yet applied. Persons meeting criteria and without health coverage who have behavioral health or substance use disorders may end up in emergency departments or jails. Due to the lack of enrollment for Medicaid services, these persons often do not have ready access to services that may mitigate the need for more costly, high levels of care and opportunities are missed to intervene on symptoms prior to reaching crisis level.

Funding to support the creation of CCBHCs in states has occurred in four ways (The National Council for Mental Wellbeing, 2021):

1. Federal Medicaid demonstration grants offering enhanced rates. These exist in ten states and no CMHCs in Mississippi have this grant.

2. SAMHSA expansion grants awarded directly to individual CMHCs. In Mississippi three CMHCs have applied for and were awarded CCBHC Expansion Grants (Regions 2, 11, and 14). These are two-year grants and there is no funding mechanism at the end of the two-year period suggesting that services and staff hired using these grant funds may dissipate once funding ends. Sustaining the services would require Medicaid funding or state funding available within two years.
3. Independent state Medicaid initiatives utilizing the 1115 Waiver or State Plan Amendments (SPA), bringing permanent sustainability to the CCBHC model.
4. State-legislated funding initiatives allowing a financial "bridge" while states pursue implementation of an 1115 Waiver or SPA.

Grants are designed to support only readiness and are time-limited. Sustainability of the CCBHC requires implementation of an 1115 Waiver or SPA. Centers for Medicare and Medicaid Services (CMS) recommends 18 months to draft the waiver and obtain approval.

The Excellence in Mental Health and Addiction Act demonstration program established a federal definition for a CCBHC and criteria necessary to achieve the CCBHC designation. Six areas are targeted for improvement: staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority. The goals of the model are to provide services; advance integration of behavioral health and physical health; assimilate and utilizing evidence-based practices on a more consistent basis; and promote improved access to high quality care. Nine types of services are required which support an emphasis on 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care (The National Council CCBHC Success Center, 2021). To offer state certification for CCBHCs, states have to develop a certification process that addresses 114 certification criteria established by SAMHSA and 21 performance measures. Additionally, CCBHCs complete standardized cost reports detailing financial information, benchmarking over time and across individual CCBHCs. There are key differences between traditional service delivery models and the CCBHC model. *See Appendix A: Key Differences: CMHC vs. CCBHC* (The National Council CCBHC Success Center, 2021).

The CCBHC model is a potential solution for existing barriers to quality care. CMHCs report substantial workforce shortages. *See OCMHA Quarterly Status Report for July 1, 2021 – September 30, 2021.* Staff vacancies reduce access (Weinberg, 2021), increase costs, reduce the quality of services and affect the level of care and appropriateness of treatment (Office, 2021). Insufficient staff salaries reduce retention and is a primary obstacle to recruitment and retention. (American Hospital Association , 2016). When there are significant shortages, services are prioritized for persons with the most severe illnesses and patients with milder symptoms may have more limited access. Further, wait times for appointments are increased, which can lead to accessing care in more expensive crisis services and emergency room (ER) utilization. Mississippi may be consistent with these national trends.

A key component of the CCBHC model is the use of a Prospective Payment System (PPS) to reimburse for services provided. The increased rates are used to cover the costs of an enhanced workforce through paying competitive wages and increasing training in care coordination and evidence-based practices (EBPs); mitigate the addiction crisis including the required provision of medication assisted treatment for opioid and alcohol use disorders; increase outreach, education, and engagement; offer services in alternate locations such as homes, emergency rooms, and jails; and improve the exchange of electronic information, data collection, and quality reporting.

According to a presentation by Dr. Joe Parks of the National Council (Parks, 2021) to the Mississippi Division of Medicaid's Medical Care Advisory Committee on October 1, 2021, the following are implications of a PPS compared with the Fee for Service (FFS) model largely utilized in Mississippi:

- Rates are clinic-specific, which account for varying costs of different CMHCs
- Payment is the same regardless of intensity or quantity received
- Does not prioritize higher-margin services over services that may be a better fit
- Offers no financial incentive to provide lots of units of service when fewer services would be as effective
- Does not require that all services be translated into units and therefore supports non-billable activities (care coordination, outreach, workforce training, technology enhancements, data analysis)

Mississippi currently has three CMHCs who receive CCBHC funding from SAMHSA, a federal agency. At the end of their respective grant periods, no financing is in place in Mississippi and the agencies risk losing the ability to function as CCBHCs. As indicated above there are two primary mechanisms for states to create an enhanced Medicaid rate that utilizes PPS:

1. 1115 Waiver (example: Texas)
2. State Plan Amendment (SPA) (examples: Oklahoma, Minnesota, Missouri, Nevada)

CCBHCs offer a new way of delivering care and facilitates purposeful, structured collaboration with community partners to maximize impact on individuals receiving care. Through the use of PPS payment system, CCBHCs can support the costs of increasing the scope of services, increasing staffing, and increasing coordinated partnerships. According to the National Council CCBHC Success Center (The National Council for Mental Wellbeing, 2021), in states where the model has taken hold, the following outcomes are reported:

- Reduced hospitalization;
- Increased jail diversion;
- Increased access to services;

- Elimination of wait lists;
- Reduced health issues; and
- Increased veterans' services (The National Council CCBHC Success Center, 2021).

A review of state CCBHC implementation efforts (The National Council CCBHC Success Center, 2021) illustrated the following examples of service delivery changes: increase in psychiatric staff; increased staff with addiction experience; improved recruitment and staff retention to reduce workforce shortages; same day access or less than 10 days; crisis care coordination; increased access to medication assisted treatment for addictive disorders; increased availability of peer support; expanded services to veterans; improved reporting on standardized quality measures; care coordination with health care providers, criminal justice organizations, and schools; and a sustainable payment model. In return for increasing and improving services and collaborations, state officials report lowered costs, improved outcomes, and improved behavioral health system capacity and infrastructure.

CCBHC implementation and outcomes vary in each state based on need. The table below offers a snapshot of initiatives and/or outcomes from three states who have implemented the model.

Figure 1: Implementation Style and Reported Outcomes (The National Council for Mental Wellbeing, 2021)

STATE	***IMPLEMENTATION STYLE AND/OR OUTCOMES***
Missouri	○ 23% increase in number served ○ 19% increase in veterans served ○ 36% decrease in ER visits (in six years) ○ 20% decrease in hospitalizations (in six years) ○ 53,295 referrals from law enforcement between 2017-2020 ○ Creation of six new crisis stabilization centers (CSCs), one in each Highway Patrol troop district
Oklahoma	○ Added seven additional Urgent Recovery Centers to mitigate referrals to crisis stabilization centers ○ Clients receive a tablet equipped with a crisis button allowing them to have access to services ○ Tablets with a crisis button placed in the vehicles of law enforcement ○ Created 981 new jobs ○ Saved $34,954,525 annually ○ Decreased time from request to initial assessment to within 3.2 days ○ 75% of adults seen within seven days following a hospitalization and 93% seen within 30 days ○ 21% decrease in utilization of psychiatric beds ○ 14% reduction in ER visits ○ 69% decrease in use of crisis substance use services ○ 70% change in receiving a suicide risk assessment

Kansas	○ Formed Mental Health Modernization Committee made up of 13 members of the Kansas House and Senate and created the following three workgroups made up of 25 non-legislative, behavioral health stakeholders
	  ○ Finance and Sustainability
	  ○ Policy and Treatment

    - System Capacity and Transformation
  - Placed a mental health liaison in each school and behavioral health workers provide services in schools after hours
  - Created legislation to facilitate implementation of CCBHC model that was signed into law 4/22/21. This legislation puts CCBHCs on the same financial sustainability level as exists for Federally Qualified Health Centers (FQHCs).

The National Council is referred to often within this document as they work with numerous states to help facilitate implementation of the CCBHC model. The National Council works with states to:

- Provide advice on the 1115 Waiver approach
- Offer lessons learned from other states
- Offer an implementation "roadmap"
- Provide training for prospective CCBHCs
- Provide data informational materials

The CCBHC model promotes integration with physical care. While some CCBHCs offer substantial amounts of traditional primary care services, the CCBHC model promotes increased care coordination with existing primary care providers (FQHCs or other Primary Care Physicians and organizations) rather than requiring development of a primary care clinic within the CCBHC. In addition to expanding and enhancing partnerships with primary care providers, many CCBHCs have increased available onsite health screenings such as screening for tobacco use, weight, cholesterol, body mass index, and blood pressure and lipid profiles and glucose screenings to help identify, intervene and treat chronic conditions like diabetes and hypertension (The National Council for Mental Wellbeing, 2021).

The Mississippi Department of Mental Health (DMH) and a CMHC representative participated in a 12-week State Level Technical Assistance CCBHC Learning Collaborative through the Mental Health Technology Transfer Center during September through December 2021. If the state chooses to utilize the CCBHC model, an important planning step for implementation would be to identify opportunities for enhancing federal Medicaid match funds. Other states report cost savings as a result of implementation of the CCBHC model. Further assessment should be done to determine how behavioral health services currently offered at CMHCs using 100% state and county source funds can be redirected as these services become required components of the CCBHC model. Once the services are covered by the enhanced Medicaid rate, these state source funds can be freed up for utilization to pursue federal Medicaid match dollars.

Commitments for Behavioral Health Disorders

Behavioral health civil commitments comprise a legal process involving filing an affidavit with the county chancery clerk. A judge uses the information presented to determine if a commitment for care is warranted, and if so, at which level of care (inpatient or outpatient). Crisis Stabilization Units (CSUs) are often used to successfully stabilize and divert individuals from

inpatient placement at state hospitals. According to DMH, CSUs provided treatment to 3,022 people during FY21 and 89% of these individuals were diverted from having to be admitted to a State Hospital. Inpatient placement is the highest level of care and orders an individual for treatment or evaluation in a hospital setting. Data is provided below on each CMHC region regarding the number of commitments, admissions to state-operated hospitals and the number of crisis beds per catchment area population.[1]

Table 1: Regional Averages

CMHC Region	Average Number of Commitments 2020/2021	Average Commitment per population	Average Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
1	172	1 / 290	35	49,985	1 per 6,248
2	334	1 / 533	187	178,337	1 per 14,784
3	336	1 / 687	132	231,049	1 per 28,881
4	385	1 / 765	147	294,762	1 per 14,784
6	492	1 / 423	106	208,446	1 per 8,852
7	345	1 / 501	117	172,947	1 per 21,618
8	364	1 / 969	74	352,807	1 per 22,050
9	297	1 / 753	93	223,872	1 per 13,992
10	466	1 / 491	274	229,007	1 per 14,312
11	349	1 / 400	179	139,735	1 per 17,466
12	1156	1/ 554	359	640,742	1 per 20,023
14	209	1 / 812	52	169,877	1 per 21,234
15	74	1 / 1011	29	74,841	NA

The number of average commitments per person ranged from 1 per 290 in Region 1 to 1,011 in Region 15. Region 1 offers the lowest ratio of number of beds per population of 1/6,248, while Region 3 offers the highest ratio of 1/28,881.

[1] In Tables 1-15, the number of civil commitments was provided by the chancery clerks and the number of admissions to the State Hospitals were provided by DMH (Mississippi Department of Mental Health FY21 Annual Report).

Region 1 CMHC

Region 1 CMHC consists of four counties with a total population of 49,985. As of November 8, 2021, there were 18,637 total Medicaid recipients in the region or 37.2% of the population. Region 1 CMHC operates an eight-bed CSU located in Marks, Mississippi.

Table 2: Region 1 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Coahoma	114	1 / 185	20	21,162	
Quitman	17	1 / 368	2	6,266	
Tallahatchie	20	1 / 675	4	13,505	
Tunica	21	1 / 431	9	9,052	
Region Average	**172**	**1 / 290**	**35**	**49,985**	**1 per 6,248**

Region 2 CMHC

Region 2 CMHC consists of six counties with a total population of 178,337. As of November 8, 2021, there were 40,127 total Medicaid recipients in the region or 22.5% of the population. Region 2 CMHC does not operate a CSU. There is one 16 bed CSU in Batesville, Mississippi operated by Region 4 CMHC that accepts people from Desoto County (Region 4) and the Region 2 catchment area.

Table 3: Region 2 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	*Number of Crisis Beds per Population
Calhoun	39	1 / 364	16	14,219	
Lafayette	82	1 / 670	56	54,973	
Marshall	39	1 / 897	10	35,010	
Panola	129	1 / 265	68	34,264	
Tate	29	1 / 974	16	28,269	
Yalobusha	16	1 / 725	21	11,602	
Region Average	**334**	**1 / 533**	**187**	**178,337**	**1 per 14,784**

*This includes both Region 2 CMHC and Region 4 CMHC Crisis Beds per Population

Region 3 CMHC

Region 3 CMHC consists of seven counties with a total population of 231,049. As of November 8, 2021, there were 52,526 total Medicaid recipients in the region or 22.7% of the population. Region 3 CMHC operates an eight bed CSU in Tupelo, Mississippi.

Table 4: Region 3 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Benton	34	1 / 243	4	8,291	
Chickasaw	20	1 / 855	31	17,109	
Itawamba	42	1 / 553	13	23,248	
Lee	125	1 / 686	54	85,756	
Monroe	37	1 / 937	15	34,670	
Pontotoc	61	1 / 546	11	32,760	
Union	17	1 / 1718	4	29,215	
Region Average	**336**	**1 / 687**	**132**	**231,049**	**1 per 28,881**

Region 4 CMHC

Region 4 CMHC consists of five counties with a total population of 294,762. As of November 8, 2021, there were 52,402 total Medicaid recipients in the region or 17.7% of the population. Region 4 CMHC operates a 16 bed CSU in Corinth, Mississippi and a 16 bed CSU in Batesville, Mississippi that accepts people from Desoto County (Region 4) and Region 2 catchment area.

Table 5: Region 4 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	*Number of Crisis Beds per Population
Alcorn	62	1 / 600	18	37,239	
DeSoto	199	1 / 959	89	190,971	
Prentiss	70	1 / 360	19	25,202	
Tippah	39	1 / 563	8	21,967	
Tishomingo	15	1 / 1292	13	19,383	
Region Average	**385**	**1 / 765**	**147**	**294,762**	**1 per 14,784**

*This includes both Region 2 CMHC and Region 4 CMHC Crisis Beds per Population

Region 6 CMHC

Region 6 CMHC consists of twelve counties with a total population of 208,446. As of November 8, 2021, there were 70,413 total Medicaid recipients in the region or 33.7% of the population. Region 6 CMHC operates a 16 bed CSU in Cleveland, Mississippi, and a 16 bed CSU in Grenada, Mississippi.

Table 6: Region 6 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Attala	30	1 / 595	5	17,866	
Bolivar	79	1 / 375	17	29,654	
Carroll	17	1 / 588	4	10,001	
Grenada	23	1 / 882	12	20,306	
Holmes	79	1 / 204	13	16,142	
Humphreys	14	1 / 548	8	7,680	
Issaquena	0	0	0	1,367	
Leflore	107	1 / 255	17	27,317	
Montgomery	17	1 / 549	4	9,337	
Sharkey	8	1 / 526	1	4,213	
Sunflower	34	1 / 673	6	22,908	
Washington	84	1 / 495	19	41,655	
Region Average	**492**	**1 / 423**	**106**	**208,446**	**1 per 8,852**

Region 7 CMHC

Region 7 CMHC consists of seven counties with a total population of 172,947. As of November 8, 2021, there were 38,864 total Medicaid recipients in the region or 22.4% of the population. Region 7 CMHC operates an eight bed CSU in West Point, Mississippi.

Table 7: Region 7 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Choctaw	21	1 / 477	11	8,100	
Clay	60	1 / 319	20	19,140	
Lowndes	150	1 / 388	30	58,265	
Noxubee	43	1 / 236	17	10,151	
Oktibbeha	35	1 / 1436	23	50,263	
Webster	8	1 / 1186	3	9,491	
Winston	28	1 / 626	13	17,537	
Region Average	**345**	**1 / 501**	**117**	**172,947**	**1 per 21,618**

Region 8 CMHC

Region 8 CMHC consists of five counties with a total population of 352,807. As of November 8, 2021, there were 59,108 total Medicaid recipients in the region or 16.7% of the population. Region 8 CMHC operates a 16 bed CSU in Brookhaven, Mississippi.

Table 8: Region 8 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Copiah	44	1 / 622	5	27,395	
Lincoln	85	1 / 400	10	34,039	
Madison	21	1 / 5120	5	107,520	
Rankin	130	1 / 1210	30	157,313	
Simpson	84	1 / 315	24	26,540	
Region Average	**364**	**1 / 969**	**74**	**352,807**	**1 per 22,050**

Region 9 CMHC

Region 9 CMHC consists of one county with a total population of 223,872. As of November 8, 2021, there were 61,308 total Medicaid recipients in the region or 26.9% of the population. Region 9 CMHC operates a 16 bed CSU in Jackson, Mississippi.

Table 9: Region 9 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Hinds	**297**	**1 / 753**	**93**	**223,872**	**1 per 13,992**

Region 10 CMHC

Region 10 CMHC consists of nine counties with a total population of 229,007. As of November 8, 2021, there were 62,325 total Medicaid recipients in the region or 27.2% of the population. Region 10 CMHC operates a 16 bed CSU in Newton, Mississippi.

Table 10: Region 10 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Clarke	75	1 / 206	13	15,453	
Jasper	36	1 / 452	21	16,299	
Kemper	5	1 / 1952	3	9,760	
Lauderdale	167	1 / 430	126	71,899	
Leake	49	1 / 464	23	22,776	
Neshoba	20	1 / 1452	11	29,052	
Newton	37	1 / 549	28	20,344	
Scott	51	1 / 543	32	27,734	
Smith	26	1 / 603	17	15,690	
Region Average	**466**	**1 / 491**	**274**	**229,007**	**1 per 14,312**

Region 11 CMHC

Region 11 CMHC consists of nine counties with a total population of 139,735. As of November 8, 2021, there were 39,134 total Medicaid recipients in the region or 28% of the population. Region 11 CMHC operates an eight bed CSU in Natchez, Mississippi.

Table 11: Region 11 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Adams	45	1 / 666	40	29,991	
Amite	26	1 / 470	16	12,237	
Claiborne	27	1 / 326	6	8,820	
Franklin	18	1 / 423	5	7,623	
Jefferson	22	1 / 308	8	6,784	
Lawrence	65	1 / 197	16	12,862	
Pike	83	1 / 471	45	39,104	
Walthall	11	1 / 1271	15	13,986	
Wilkinson	52	1 / 158	28	8,328	
Region Average	**349**	**1 / 400**	**179**	**137,735**	**1 per 17,466**

Region 12 CMHC

Region 12 CMHC consists of thirteen counties with a total population of 640,742. As of November 8, 2021, there were 144,132 total Medicaid recipients in the region or 22.4% of the population. Region 12 CMHC operates a 16 bed CSU in Jones County, Mississippi and a 16 bed CSU in Gulfport, Mississippi.

Table 12: Region 12 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Covington	30	608	14	18,258	
Forrest	177	422	86	74,867	
Greene	3	4255	2	12,766	
Hancock	54	895	70	48,340	
Harrison	407	520	15	211,672	
Jefferson Davis	86	127	13	10,954	
Jones	106	640	38	67,902	
Lamar	56	1156	38	64,755	
Marion	42	576	27	24,215	
Pearl River	120	466	42	55,959	
Perry	15	805	5	12,083	
Stone	10	1901	0	19,014	
Wayne	50	399	9	19,957	
Region Average	**1156**	**1/ 554**	**359**	**640,742**	**1 per 20,023**

Region 14 CMHC

Region 14 CMHC consists of two counties with a total population of 169,877. As of November 8, 2021, there were 32,537 total Medicaid recipients in the region or 19.1% of the population. Region 14 CMHC operates an eight CSU located in Gautier, Mississippi.

Table 13: Region 14 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
George	40	1 / 632	8	25,280	
Jackson	169	1 / 855	44	144,597	
Region Average	**209**	**1 / 812**	**52**	**169,877**	**1 per 21,234**

Region 15 CMHC

Region 15 CMHC consists of two counties with a total population of 74,841. As of November 8, 2021, there were 19,337 total Medicaid recipients in the region or 25.8% of the population. Region 15 CMHC does not operate a CSU but has informal agreements with River Region Behavioral Health in Vicksburg, Region 6 CMHC and Region 8 CMHC for CSU services.

Table 14: Region 15 CMHC Comparison Data

County	Number of Commitments 2020/2021	Commitment per population	Admissions to State Hospitals 2020/2021	Population	Number of Crisis Beds per Population
Warren	34	1 / 1292	21	43,957	
Yazoo	40	1 / 772	8	30,884	
Region Average	**74**	**1 / 1011**	**29**	**74,841**	**NA**

Crisis Intervention Teams (CIT)

A Crisis Intervention Team (CIT) is a community partnership among a law enforcement agency, a CMHC, a hospital, other mental health providers, consumers and family members of consumers. A CIT officer is a law enforcement officer who is authorized to make arrests under MCA § 99-3-1, trained and certified in crisis intervention, and working for a law enforcement agency that is a participating partner in a CIT. Officers who have received crisis intervention training respond to individuals experiencing a mental health crisis and divert them to an appropriate setting to provide treatment, ensuring individuals are not arrested and taken to jail due to the symptoms of their illness (Mississippi Department of Mental Health, 2022; Mississippi Department of Mental Health FY2020 Annual Report, 2020). CITs are a nationally recognized best practice, and officers who have received CIT training have been recognized as having the understanding and skills needed to resolve mental health and substance use crises.

MCA § 41-21-133 authorizes law enforcement agencies and community mental health centers to partner to establish CITs to provide psychiatric emergency and referral services as an alternative to jail. Specifically, MCA § 41-21-133 provides as follows:

> (1) Any law enforcement agency or community mental health center, as a participating partner, is authorized to establish Crisis Intervention Teams to provide for psychiatric emergency services and triage and referral services for persons who are with substantial likelihood of bodily harm as a more humane alternative to confinement in a jail.

The model for CIT used in Mississippi is the "Memphis Model." The model offers a police-based first responder program aimed at pre-arrest jail diversion for those in a mental illness crisis

and is generally based in the patrol division. CIT officers effectively divert persons in mental health crisis away from jail and into appropriate mental health settings. CIT works in partnership with behavioral health providers to provide a system of services that is friendly to the individuals with mental illness, family members, and the police officers. Officers are trained to have the empathy and technical skills necessary for the successful resolution of a mental health crisis and has been recognized as a best practice model. (University of Memphis CIT Center, 2021).

The first CIT in Mississippi was created in 2009-2010 in partnership between Region 10 CMHC (Weems) and the Lauderdale County Sheriff's Office. Additional training was initiated for officers and mental health professionals, including a CIT Train-the-Trainer program at the University of Southern Mississippi in June 2012, resulting in certification as CIT Memphis-Model Verbal De-escalation Instructors. From that point on, CIT Officer Certification Training was offered in Region 10 including the training of mental health didactics, verbal de-escalation strategies and techniques, procedures for site visits to local mental health facilities, and protocols for face-to-face interaction with consumers (clients).

In 2015, DMH deemed the East Mississippi (Region 10) CIT Partnership and their CIT Training a model program for the state. DMH contracted with the Lauderdale County Sheriff's Office to make CIT Training available to law enforcement agencies (LEAs) within other mental health regions in the state. Lauderdale County Sheriff's Office hired a Training Coordinator on a part-time basis (Captain Wade Johnson, Meridian Police Department, retired). New CIT partnerships were formed by LEAs and CMHCs, identifying and defining available mental health resources prior to training, allowing officers to become knowledgeable of the resources in their catchment area.

Eventually, the demand for training substantially increased and the availability of the training was expanded. CIT (Memphis Model) Train-the-Trainer events were held to certify mental health professionals and CIT Officers as trainers. Region 10 CIT Partnership has focused efforts on law enforcement officers (LEOs) in their region, plus other agencies statewide with an emphasis on North Mississippi. The Regions 2 and 3 CIT Partnership completed their first training event in October 2021. The Region 12 CIT Partnership has focused primarily on training LEOs from their region, including the Gulf Coast area.

Due to the number of courses and training modules in a 40-hour curriculum, CIT training is costly. Mental health experts give approximately 18-20 hours of lectures on a wide array of mental health issues. The training not only includes lectures, it also includes 11-12 hours of de-escalation instruction and role play that must be conducted by trainers certified by the University of Memphis CIT Center. *See Appendix B: Sample CIT Training Agenda.*

Through grants from DMH to Lauderdale County Sheriff's Department and Pine Belt Mental Health, CIT expansion efforts are ongoing to help establish fully functional CIT programs in other communities. These communities are Corinth/Alcorn County, Greenwood/Leflore County, Arcola/Washington County, Clarksdale, Grenada, Natchez/Adams County, and Senatobia. Pine Belt Mental Health Resources (PBMHR) is also in the fourth year of a five year SAMSHA grant to expand CIT across the southern half of Mississippi. PBMHR receives approximately $300,000 each year from that grant. In FY21, the following achievements were attained (Mississippi Department of Mental Health FY2021 Annual Report, 2021):

- 13 CIT classes were conducted, with 49 law enforcement agencies participating
- 151 officers received training and certification as CIT officers

Although many officers in Mississippi have received training, the following is required in order to have a CIT.

§ 41-21-133. Establishment of Crisis Intervention Teams.

(2) A Crisis Intervention Team shall have one or more designated hospitals within the specified catchment area that has agreed to serve as a single point of entry and to provide psychiatric emergency services, triage and referral services and other appropriate medical services for persons in custody of a CIT officer or referred by the community mental health center within the specified catchment area.

Mississippi now has the following eight fully-functioning CIT programs:

- East Mississippi CIT serves Lauderdale Kemper, Clark, Smith, Scott, Newton, Neshoba, Leake, and Jasper counties
- Pine Belt CIT serves Forrest, Lamar, Marion, Perry, Covington, Jeff Davis, Jones, and Pearl River counties
- LIFECORE Health Group CIT serves Lee and Itawamba counties
- Hinds County CIT serves Hinds County
- Pike County CIT serves Pike County
- Northwest Mississippi CIT serves DeSoto county
- Oxford CIT serves Oxford and Lafayette counties

Issue: Crisis Intervention Teams	
CIT has proven to be a successful model for law enforcement to deal with situations involving individuals with serious mental illness.	
Background	§ 41-21-135. Oversight of Crisis Intervention Teams by community mental health centers; collaborative agreements among community health center, law enforcement agency and hospital that will serve as single point of entry. (1) Community mental health centers shall have oversight of Crisis Intervention Teams operating within their service areas. § 41-21-143. Active encouragement of hospitals and law enforcement agencies to develop Crisis Intervention Teams and comprehensive psychiatric emergency services. (1) Community mental health center directors shall actively encourage hospitals to develop comprehensive psychiatric emergency services. If a collaborative agreement can be negotiated with a hospital that can provide a comprehensive psychiatric emergency service, that hospital shall be given priority when designating the single point of entry. (2) The State Department of Mental Health shall encourage community mental health center directors to actively work with hospitals and law enforcement agencies to develop Crisis Intervention Teams and comprehensive psychiatric emergency services and shall facilitate the development of those programs.
Recommendation:	OCMHA recommends that all CMHC regions pursue and promote the development of CIT in their catchment area.

Alternative Living Arrangements for Persons with Serious Mental Illness

Creating Housing Options in Communities for Everyone (CHOICE) supported housing program was created in FY16 when the Mississippi Legislature appropriated funding to establish a housing partnership. CHOICE is a partnership between DMH, Mississippi Home Corporation, Mississippi United to End Homelessness (MUTEH), and Open Doors Homeless Coalition. The Mississippi Home Corporation reported that 258 individuals received housing services through CHOICE during FY20. MUTEH can house individuals in all 82 Mississippi counties, and Open Doors can house them in the southern-most six counties in the state. CHOICE can provide

funding for a security deposit, utility deposit, and up to 12 months of rent. While CHOICE provides the assistance that makes the housing affordable, local CMHCs provide the needed services, all based on the needs of the individual. The program is available in all CMHC regions (Mississippi Department of Mental Health FY2020 Annual Report, 2020). This report is available at http://www.dmh.ms.gov/wp-content/uploads/2021/11/DMH-FY21-Annual-Report.pdf.

CMHCs shall pursue and promote alternative living arrangements for persons with serious mental illness, including, but not limited to, group homes for persons with chronic mental illness. MCA § 41-19-33.1(t). DMH currently provides partial funding to seven CMHCs for alternative living arrangements. These options are Supervised Group Housing and Supported Living Services. *DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, And Substance Use* offers the following descriptions:

> "Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of a person's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance."
>
> "Supported Living Services is provided to people who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported Living Services is for people who need less than twenty-four (24) hour employee support per day. Employees must be on-call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living Services are provided in a home-like setting where people have access to the community at large to the same extent as people who do not have a serious mental illness (DMH 2020 Operational Standards Mental Health, Intellectual/Developmental Disabilities, And Substance Use Community Service Providers)."

Currently, seven of thirteen CMHCs have Supervised and/or Supported living options for people with SMI. Table 15 is comprised of information made available by DMH and illustrates supervised living options and which CMHCs provide them.

Table 15: CMHC Living Options Funded by DMH

Region	DMH Funding Amount	County Located In	Supervised / Supported	DMH Approved Beds	*Filled Beds	Funding per approved bed
2	$128,963	Lafayette	Supervised	6	6	$21,493.00
3	$82,076	Lee	Supervised	9	6	$9,119.55
**6	$1,098,152	Washington	Supervised	15	15	$8,512.80
6		Leflore	Supervised	40	31	$8,512.80
6		Leflore	Supported	46	36	$8,512.80
6		Bolivar	Supported	14	12	$8,512.80
6		Sharkey	Supported	14	14	$8,512.80
7	$257,914	Clay	Supported	24	19	$4,776.18
7		Winston	Supported	30	28	$4,776.18
8	$77,983	Rankin	Supported	8	6	$9,747.87
12	$486,000	Lamar	Supervised	10	8	$15,677.41
12		Forrest	Supervised	7	7	$15,677.41
12		Marion	Supervised	14	14	$15,677.41
**15	$327,037	Warren	Supervised	15	10	$9,910.21
15		Yazoo	Supervised	12	12	$9,910.21
15		Warren	Supported	2	2	$9,910.21
15		Yazoo	Supported	4	3	$9,910.21
Total	$2,458,125			270	229	$9,104.16

* *The number of filled beds is based on data gathered on 9/22/21. These numbers are subject to change daily.*

** *Region 6 CMHC (Life Help) and Region 15 CMHC (Warren-Yazoo Behavioral Health) each receive one grant to provide both Supervised and Supported Housing.*

Issue: Alternative Living Arrangements for Persons with Serious Mental Illness	
OCMHA has had the opportunity to visit many counties in Mississippi and receive feedback from stakeholders regarding strengths and concerns. One consistent issue that arises is that many community members are unaware of the services available in their individual county. Further, many stakeholders, such as emergency room personnel and first responders, do not know the process of accessing services in their county. *See Recommendation 3 in the Quarterly Status Report July 1 through September 30, 2021, at pp. 13-14.* In November, DMH issued a bid to establish a contract for the development and implementation of a public awareness and media campaign to increase the public's knowledge of community behavioral health services in the state.	
Background	§ 41-19-33. Regional commissions; establishment; duties and authority. (1) Each region so designated or established under Section 41-19-31 shall establish a regional commission to be composed of members appointed by the boards of supervisors of the various counties in the region. It shall be the duty of such regional commission to administer mental health/intellectual disability programs certified and required by the State Board of Mental Health and as specified in Section 41-4-1(2). In addition, once designated and established as provided hereinabove, a regional commission shall have the following authority and shall pursue and promote the following general purposes: (t)To provide alternative living arrangements for persons with serious mental illness, including, but not limited to, group homes for persons with chronic mental illness.
Recommendation:	OCMHA recommends that all CMHC regions pursue and promote alternative living arrangements for persons with SMI, including, but not limited to, group homes for persons with chronic mental illness.

Appendix A

Key Differences: CMHC VS. CCBHC

https://www.thenationalcouncil.org/wp-content/uploads/2019/07/CCBHC-Moving-Beyond-Business-as-Usual-5-2019.pdf?daf=375ateTbd56

	Traditional Delivery Models	CCBHC Service Delivery
Access to Care	Low reimbursement rates result in workforce shortages, inability to recruit and retain qualified staff and limited capacity to meet the demand for treatment resulting in clinics turning away patients or placing them on long waiting lists.	CCBHCs are required to serve everyone, regardless of geographic location or ability to pay. Nationally, 100% of CCBHCs have hired new staff including 72 psychiatrists and 212 staff with addiction specialty focus expanding their capacity to meet the demand for treatment. As a result, CCBHCs report an aggregate increase of 25% in patient caseload.
Wait Times	Wait times from referral to first appointment average 48 days nationally at community- based behavioral health clinics.	For routine needs, 46% of CCBHCs offer same- day access to services and 94% offer access within 10 days or less.
Evidence- based Practices (EBPs)	No standard definition of services that requires evidence-based practices. Services vary widely between clinics with little guarantee that clients will have access to high quality, comprehensive care. Array of services and staff training is dependent upon grant funds.	CCBHCs are required to provide a comprehensive array of services including 24/7 crisis services, integrated healthcare,care coordination, medication-assisted treatment (MAT), peer and family support and care coordination. Across CCBHCs, 75% have expanded capacity to provide crisis care, 73% have adopted innovative technologies to support care, 57% have implemented same-day access protocols and 64% have expanded services to veterans.
Quality Measures	Quality measures are inconsistent across states, communities and grant programs.	Clinics are required to report on standardized quality metrics, while states report on additional quality and cost measures. Nationally, 79% of CCBHCs reported using quality measures to change clinical practice.
Crisis Services	Crisis services provide necessary assessment, screening, triage, counseling and referral services to individuals in need but vary nationally due to limited reimbursement.	All CCBHCs offer 24/7 access to crisis care, including mobile crisis teams, ensuring individuals of all ages receive the care they need and avoid unnecessary hospitalizations. A CCBHC in Oklahoma reported a 64% reduction in psychiatric hospitalizations as a result of its crisis response activities and improved care transitions with the hospital.
Care Coordination	Care coordination and integration of physical and behavioral health care services result in improved health outcomes and reduced costs. Traditional reimbursement does not cover care coordination services; therefore, physical and behavioral	CCBHCs are required to coordinate care with hospitals, schools, criminal justice agencies and other providers to improve health outcomes and reduce use of emergency room and inpatient facilities. Estimated savings of guiding one high-resource-user to care coordination is estimated to be $39,000 per year. These activities are incorporated into the reimbursement rate.

Referenced: Certified Community Behavioral Health Clinics Moving Beyond "Business as Usual" to Fill the Addiction and Mental Health Treatment Gap. (2021).www.The National Council.org.

Appendix B

Sample CIT Training Agenda

Monday, June 7, 2021

08:00	**Welcome**	**Billy Sollie, Sheriff, Lauderdale County** **Chief Chris Read, Meridian Police** **Dr. John Temple, LCSO Chaplain**
08:10	**Introductions and Pre-Test** ▫ Introductions ▪ Trainers & Participants ▫ Overview of Schedule ▫ Pre-Test **Introduction to CIT/CIT Training** ▫ History, Memphis Model, Etc.	**Captain Wade Johnson (MPD, retired)** **Lauderdale County Sheriff Office** **East Mississippi Crisis Intervention Team** **Training Coordinator** **Chief Deputy Ward Calhoun** **Lauderdale County Sheriff Office**
08:30	**Introduction to Clinical States**	**Elon Espey CSU**
09:30	**Personality Disorders**	**Elon Espey CSU**
10:20	*Break*	
10:30	**Hearing Voices Exercise**	**Wynter Ward, WCMHC** **Capt. W. Johnson**
12:00	*Lunch*	
13:00	**Substance Abuse/Co-occurring Diagnosis**	**Dr. Lin Hogan, Weems**
14:00	**Cultural Competence**	**Dr. Lin Hogan, Weems**
15:00	*Break*	
15:10	**CIT Officers "Stories from the Field"**	**Current CIT Officers**
16:00	**Overview of Mental Health Services/ Community Resources, Q&A**	**Weems Community Mental Health/Alliance Health Center**
17:00	*Dismiss*	

Tuesday, June 8, 2021

08:00	**Medication**	**Noel Palmer Weems Community MHC**
09:30	**CIT Discussion, Confidentiality**	**CIT Instructors**
10:00	*Travel to CMRC*	
10:4	**Suicide**	**CMRC/EMSH**
11:45	**LUNCH & Meet with Clients**	**Frankie Johnson, CMRC/EMSH**
13:15	**Region 10 Crisis Stabilization Unit**	**R10 CSU Staff**
13:45	*Travel to Alliance*	
14:45	**Alliance Health Center** ▫ Tour and Meet with Clients ▫ Adolescent Protocol	**Alliance Health Center James Abraham**
16:00	*Return to training room/Site Visit Discussion*	
17:00	*Dismiss*	

Wednesday, June 9, 2021

08:00	**Site Visits/Class Discussion**	**CIT Training Staff**
08:30	**Youth and Children/IDD**	**Dr. Lee Lee Marlow, Weems Community Mental Health Center**
10:00	**Legal Aspects**	**Cyndi Eubank, Mississippi Department of Mental Health**
11:00	**Consumer Presentation**	
12:00	*Lunch*	
12:30 12:30-13:30 13:30-14:00 14:00-14:30 16:00-17:00	**Verbal De-Escalation Training** Lecture #1-Basic Verbal Skills Role Play Lecture#2-Basic De-Escalation Strategies Role Play Lecture #3- Stages of an Escalating Crisis	**Lead Mental Health Instructor Wynter Ward Weems Community Mental HC Sgt. Andy Matuszewski, LCSO EMCIT Verbal De-escalation Instructors**
17:00	*Dismiss*	

Thursday, June 10, 2021

08:00	**Review/Q&A**	**CIT Instructors**
08:30	**PTSD and Traumatic Brain Injury**	**CIT Staff**
10:00	**Mississippi Department of Mental Health**	**Brent Hurley**
11:00	**Officer Wellness**	**CIT Staff**
12:00	*Lunch*	
13:00 13:00-13:30 13:30-17:00	**Verbal De-Escalation Training** Lecture # 4 – Advanced Verbal Skills "12 Guardrails" for CIT Officers Role Play	**Sgt Andy Matuszewski** **LCSO** **Role Play**
17:00	**Evening Meal with National Alliance on the Mentally Ill (NAMI)**	**NAMI-Meridian, Jill Walsh** **NAMI-Mississippi, Patricia Battle**
19:00	Dismiss	

Friday, June 11, 2021

08:00 08:00-08:30 08:30-11:30	**Verbal De-Escalation Training** Lecture #5 – Complex Crisis Intervention Strategies Role Play	**Wynter Ward** **Weems CMHC** **EMCIT Verbal De-escalation Instructors**
11:30	**Working Lunch** **Policies & Procedures** **Q&A – CIT Wrap-up** ▫ **Post-Test** ▫ **Evaluation**	**CIT Instructors**
2:00	***Graduation***	**Meridian City Hall, 3rd Floor** **623 23rd Avenue** **Meridian, MS 39301**

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