Rose Isabel Williams Mental Health Reform Act of 2020

Quarterly Status Report
April 1, 2021 – June 30, 2021

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

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Quarterly Status Report
Submitted Pursuant to Mississippi Code Section 41-20-5(h)
April 1, 2021 – June 30, 2021

Scope and Purpose

Rose Isabel Williams Mental Health Reform Act of 2020. The following report is in response to the *Rose Isabel Williams Mental Health Reform Act of 2020* passed by the Mississippi legislature and codified at Section 41-20-1, *et seq.* of the Mississippi Code of 1972 (2020). The purpose of the Rose Isabel Williams Mental Health Reform Act is to:

> *"...reform the current Mississippi mental health delivery system so that necessary services, supports and operational structures for all its citizens with mental illness and/or alcohol and drug dependence and/or comorbidity, whether children, youth or adults, are accessible and delivered preferably in the communities where these citizens live."*

The Act created the position of the Coordinator of Mental Health Accessibility within the Department of Finance and Administration (DFA). The Coordinator is appointed by the Executive Director of DFA and serves at her will and pleasure. Pursuant to Miss. Code Section 41-20-5, the Coordinator has the following powers and duties:

- *(a) To perform a comprehensive review of Mississippi's mental health system to explore the availability and accessibility of services*
- *(b) To analyze and review the structure of the mental health system*
- *(c) To review the adequacy and quality of the individualized supports and services provided to persons discharged from the state hospitals or to persons at risk of institutionalization throughout the state*
- *(d) To review the quarterly financial statements and status reports of the individual community mental health centers described in Section 41-19-33(3)(b)*
- *(e) To consult with the Special Master appointed in the United States of America v. State of Mississippi, No. 3:16-CV-622-CWR-FKB (S.D. Miss. Feb. 25, 2020) or any monitor or other person appointed by the court, and all other public and private mental health stakeholders*
- *(f) To determine where the delivery or availability of services are inadequate*
- *(g) To determine whether each community mental health center has sufficient funds to provide the required services*

(h) To report on the status of the mental health system quarterly to the Governor, the Lieutenant Governor, the Speaker of the House, the State Department of Mental Health, the regional commissions, the Division of Medicaid, the State Department of Rehabilitative Services, the State Department of Health, the Department of Finance and Administration, the PEER Committee and the Legislative Budget Office

(i) In addition to the quarterly report required by paragraph (h), to provide the PEER Committee each quarter with a financial report, assessment and review of each community mental health region and other relevant matters relating to the region. The State Department of Mental Health and the regional commissions shall cooperate with the PEER Committee in its assessment and review of the community mental health regions and shall provide the committee with all necessary information and documentation as requested by committee.

To facilitate the necessary access to information, the Act requires the Department of Mental Health (DMH) and the regional Community Mental Health Center (CMHC) commissions to cooperate on the assessment and review while providing the committee with all necessary information and documentation as requested by the committee.

On October 15, 2020, Bill Rosamond, JD, was appointed as the Coordinator of Mental Health Accessibility by Liz Welch, Executive Director of the Department of Finance and Administration (DFA). Mr. Rosamond has significant experience related to public policy and mental health services, having served as the Special Assistant Attorney General assigned to DMH for five years. In this role, he helped plan the State's response to the *Olmstead* litigation filed by the U.S. Department of Justice (DOJ) against the State of Mississippi. In this ongoing lawsuit, DOJ alleges that Mississippi's mental health system violates the Americans with Disabilities Act (ADA).

Under the direction of Ms. Welch, Mr. Rosamond chose the following team members:

- Steven Allen - Mr. Allen retired as the Deputy Executive Director of the DMH after serving more than 30 years in public mental health service system.
- Jerri Avery, PhD, LPC – Dr. Avery is a licensed professional counselor with a PhD in Public Policy and Administration. She has more than 27 years of behavioral health experience, with 18 of those years spent at DMH and five at Warren-Yazoo Mental Health Services (Region 15 Community Mental Health Center).
- Jerry Mayo – Mr. Mayo retired as the Executive Director of Pine Belt Mental Health Resources (Region 12 Community Mental Health Center) with 28 years of service. Prior to becoming Executive Director, Mr. Mayo served as the Financial Officer for Pine Belt Mental Health Resources. Mr. Mayo has retired status with the American Institute of Certified Public Accountants.

Methodology

The comprehensive review will focus on conducting a qualitative and quantitative evaluation for the purposes of improving the mental health service system. The Office of the Coordinator of Mental Health Accessibility (OCMHA) has chosen to utilize an existing framework that is based on the Canadian Health System General Rating System and modified specifically for mental health services by Samartzis and Talias (2019). This framework offers evidence-based, systematic measurement and monitoring that allows for the quantification of quality indicators at the macroscopic level of the mental health system. It includes financial dimensions to help assess cost, sustainability, and sustainable development levels. The OCMHA will make necessary modifications to the framework to ensure compatibility with Mississippi's mental health system and the goals of the Act. Use of an existing framework supports development of an integrated model for evaluation and ensures the identification of specific interventions that will improve the quality of the mental health system. Strategies are in development but may include comprehensive reviews of financial reports, minutes of leadership boards and commissions, annual reports, PEER reports, and other relevant documents; meetings with stakeholders, including CMHC staff, family members, individuals served, and members of advocacy organizations; existing evidence-based models of service provision; and development of service data and methods for collecting and aggregating.

Eight dimensions to assess mental health services were proposed by Samartzis and Talias (2019). Each of the dimensions falls into one of the following categories: (a) Accessibility and adequacy of services or (b) Profitability indicators which are critical economic indicators that affect the viability and sustainability of services. The eight dimensions are as follows:

(1) **Appropriateness:** Indicates the adequacy or inadequacy of outpatient psychiatric structures in parallel with deinstitutionalization
(2) **Accessibility:** Indicates the amount of access a person has to individualized, readily available services
(3) **Acceptance:** Indicates the level of patient satisfaction
(4) **Competence:** Measures training of staff and continuous quality improvement related to assessment, diagnosis, intervention and training
(5) **Effectiveness:** Measures improvements made by persons served
(6) **Continuity of service**: Measures the rate of therapeutic continuity following discharge from higher levels of care
(7) **Efficiency:** Indicates availability and effectiveness of workforce and measures financial viability and efficacy
(8) **Safety** (for patients and for health professionals): Indicates the frequency of threats to the safety of staff and individuals

The systematic measurement and monitoring of indicators and the measurement and quantification of quality through them are the basis for evidence-based health policy for improvement of the quality of mental health services. OCMHA will identify data indicators for

each of the eight dimensions. OCMHA will carefully review the context of data collected as the numbers can be misleading. An example would be data indicating the closure of hospitals or a reduction in total inpatient bed capacity. At first glance, patterns such as these may seem like a positive indication of improvement in the mental health system. Alternatively, closures or reductions may be evidence of reduced quality of life, morbidity, and mortality if sufficient community structures are not in place to provide the necessary services.

The first step towards mental health reform is focused on an intensive exploration of the current conditions of the public mental health system in Mississippi, including the identification of its gaps, barriers and strengths. OCMHA will utilize an approach that prioritizes a review of the services provided for the most acute needs, and therefore the most costly services, such as services provided by emergency departments, inpatient providers, criminal justice agencies, and community emergency services provided by first responders.

Quarter 1 Highlights

During the first quarter, OCMHA has implemented the initial stages of assessment of the behavioral health system in Mississippi. OCMHA is seeking quantitative and qualitative data by conducting on-site interviews and tours with Executive Directors and other relevant service staff to review the current status of the organization, including financial viability. Service reviews are being conducted for counties and regions. These reviews include an examination of annual operational plans, census data, service data, etc. and will be used to determine if services are offered in each county and available to the entire population of each county, especially persons with serious and persistent mental illness. The development of a quality measuring tool has also been initiated during Quarter 1 with valuable input solicited from stakeholders, especially advocacy organizations. The purpose is to measure the quality of the individualized supports and services provided to persons receiving higher levels of care who were discharged from state hospitals or to persons at risk of institutionalization. OCMHA will use a two-pronged approach that measures average patient satisfaction using a Likert-style approach and free-text records to capture patient's experiences as recommended by Samartzis and Talias (2019). A protocol for survey administration is under development to ensure responses are elicited when critical mental capacity has been restored and the questions can be adequately understood.

Background

Stakeholders. Mississippi Peer Report #584 (Joint Legislative Committee on Performance Evaluation and Expenditure Review, 2014) identified the four entities responsible for the public mental health system in Mississippi:

1. Community Mental Health Centers
2. Board of Mental Health

3. Department of Mental Health
4. Certified, private mental health organizations

This report identifies the following additional components:

- The Division of Medicaid which plays a valuable role in creating access to behavioral healthcare for persons with low income and for the infrastructure necessary for the viability of a public mental health system.
- Advocacy organizations who offer voice to persons and families who utilize behavioral health services.

Community Mental Health Centers (CMHCs)

CMHCs are the primary service providers of community-based mental health services for adults and children with mental illnesses, substance use disorders (SUDs), and intellectual and/or developmental disabilities (Mississippi Department of Mental Health, 2021). The Regional Commission Act of 1966 authorized the creation of CMHCs. They were designed to provide local officials and residents with authority and autonomy to meet the specific mental health needs of their community. CMHCs are often misunderstood as being a state government entity that employs state employees, but such is not the case. Rather, CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors and are therefore regional entities. They operate independently of DMH but are subject to regulation by DMH through the avenues of certification and funding.

Mississippi currently has 13 CMHC Regions. *See Map of the CMHC Regions and Counties attached as Appendix "A".* The current regional distribution has experienced notable changes which are described below:

- In 2010, Region 8 CMHC (headquartered in Brandon) absorbed Lincoln County, which was previously served by Region 11 CMHC, at the request of the Lincoln County Board of Supervisors
- In 2010, DeSoto County moved from Region 2 CMHC (headquartered in Oxford) to Region 4 (headquartered in Corinth) at the request of the County Board of Supervisors.
- In 2013, Region 5 CMHC (headquartered in Greenville) was absorbed by Region 6 CMHC (headquartered in Greenwood) due to financial challenges facing the former.
- In 2021, Region 13 CMHC (headquartered in Gulfport) was absorbed by Region 12 CMHC (headquartered in Hattiesburg) due to financial and operational challenges facing the former.

There are considerable differences in the size of CMHCs in terms of numbers of persons served as well as the numbers of counties and the sheer geographical area in the respective catchment

regions. CMHCs reported serving over 110,000 Mississippians during 2018 (Smith, 2019). Their operations, however, are similar and they consequently face a shared set of similar operational issues. Some of the challenges faced are summarized below.

Funding for Mental Health Infrastructure and Services

The major funding sources are (1) Medicaid payments for covered services; (2) state and federal grants; and (3) county funds.

Medicaid. The largest amount of revenue is derived from Medicaid, which plays a key role in financing behavioral healthcare for low-income Mississippians. The majority of persons served by CMHCs have Medicaid as their source of health insurance, thereby leaving CMHCs largely Medicaid-dependent. Most beneficiaries with behavioral health conditions qualify for Medicaid due to their low incomes or disabilities. Beneficiaries often have higher expenditures due to comorbidity with other chronic health conditions. This situation is not unique to Mississippi. Nationally, enrollees with behavioral health conditions account for 48% of Medicaid spending even though they account for only 20% of enrollees (Musumeci & Garfield, 2021).

Medicaid rates generally change annually and are set at 90% of the Medicare rates for Current Procedural Terminology (CPT) codes. There are other Medicaid rates for services not reimbursed by Medicare and those rates are periodically changed to reflect the cost of providing those services. While there are some day rates for Medicaid services, most of the services are reimbursed based on an element of time measured in minutes.

Grant Funding. State and federal grant funding is the second largest revenue source for CMHCs. Grant revenues are usually fixed in amount and target a particular population and/or a specific diagnosis. There are two types of federal grants: (1) Block Grants, which are generally applied for and awarded annually; and (2) Discretionary Grants, which are time-limited and often target contemporary challenges in the form of either urgent or emergent issues. These funds are not available to address general operational issues or populations.

While a CMHC may receive grants directly from a federal agency, it is more common that federal awards are applied for at the state level and the dollars are managed by a state agency. CMHCs and other provider types are offered opportunities to submit a proposal to access the funding and are often the primary recipients of available funding that targets behavioral health. In Mississippi, most of the federal dollars and state dollars that are awarded for behavioral issues are managed by DMH. The funding mechanism is most often by cost reimbursement or purchase of service, also known as fee for service.

Self-Pay and Uncompensated Care. CMHCs report providing over $33 million in uncompensated indigent services during 2018 (Smith, 2019). CMHCs serve individuals that are

neither Medicaid recipients nor do they meet grant requirements for services. These individuals are served on a fee for service basis using a sliding fee scale. The scales are generally weighted for income and dependents and allow access to persons who are underinsured or not insured.

There is no standardized scale for CMHCs. Rather CMHCs have the autonomy to establish their own customized scales. This lack of standardization leads to differences in revenue derived from self-pay collections and estimates of uncompensated care from region to region. The percentage of these fees that are ultimately collected by CMHCs make up only a small percentage to total revenue.

County Contributions. Each year the appropriation bill for DMH includes funds for the CMHCs. However, the receipt of such funds is contingent upon receipt of required contributions from the counties served by the CMHCs. The legislation specifically indicates that the contribution must be equal to or greater than the proceeds of a three-fourths (3/4) mill tax on all taxable property in the county as determined in the county in Fiscal Year 1982 or the amount of funds contributed to the CMHC by the county in Fiscal Year 1984, whichever is greater. Additionally, Miss. Code Section 41-19-39 allows counties to levy a special tax, not to exceed two (2) mills, for the construction, operation and maintenance of the mental illness and intellectual disability facilities or services. The county contributions to the CMHCs represent about three percent of the annual revenue of the CMHCs. Table 1 lists all thirteen regions and the total of county contributions per region and the average per person contribution. Region 3 (headquartered in Tupelo) receives the lowest per person contribution at $1.12 and Region 9 (headquartered in Jackson) receives the highest at $6.56.

Table 1: County Contribution by Region

CMHC Region	Total Multi-County Contributions	Per Person
1	$139,503	$2.79
2	$251,432	$1.41
3	$259,186	$1.12
4	$362,238	$1.23
6	$971,778	$4.66
7	$259,708	$1.50
8	$607,140	$1.72
9	$1,468,663	$6.56
10	$344,958	$1.51
11	$308,174	$2.21
12	$3,480,263	$5.43
14	$453,000	$2.67
15	$191,400	$2.56

The diversity between county contributions is sizeable, with the largest contributor being Harrison County at $2,146,141 and two counties (Benton and Wilkinson) nearly in a tie for the

smallest amount of around $10,000. A schedule of counties delineated by CMHC region and each counties' annual contribution is provided below.

Table 2: Contributions by County

CMHC Region	County	Population	County Contribution
1	Coahoma County	21,162	$41,437
1	Quitman County	6,266	$25,200
1	Tallahatchie County	13,505	$18,699
1	Tunica County	9,052	$54,167
Total			$139,503
Contribution per person			$2.79
2	Calhoun County	14,219	$25,057
2	Lafayette County	54,973	$84,000
2	Marshall County	35,010	$50,000
2	Panola County	34,264	$41,375
2	Tate County	28,269	$30,000
2	Yalobusha County	11,602	$21,000
Total			$251,432
Contribution per person			$1.41
3	Benton County	8,291	$10,000
3	Chickasaw County	17,109	$29,997
3	Itawamba County	23,248	$16,878
3	Lee County	85,756	$101,411
3	Monroe County	34,670	$46,000
3	Pontotoc County	32,760	$29,400
3	Union County	29,215	$25,500
Total			$259,186
Contribution per person			$1.12
4	Alcorn	37,239	$50,038
4	DeSoto County	190,971	$200,000
4	Prentiss County	25,202	$42,000
4	Tippah County	21,967	$36,000
4	Tishomingo County	19,383	$34,200
Total			$362,238

Contribution per person			$1.23
6	Attala County	17,866	$50,000
6	Bolivar County	29,654	$243,000
6	Carroll County	10,001	$25,000
6	Grenada County	20,306	$35,881
6	Holmes County	16,142	$26,799
6	Humphreys County	7,680	$23,200
6	Issaquena County	1,367	$20,000
6	Leflore County	27,317	$121,500
6	Montgomery County	9,337	$22,598
6	Sharkey County	4,213	$49,000
6	Sunflower County	22,908	$57,300
6	Washington County	41,655	$297,500
Total			$971,778
Contribution per person			$4.66
7	Choctaw County	8,100	$24,000
7	Clay County	19,140	$24,000
7	Lowndes County	58,265	$101,708
7	Noxubee County	10,151	$25,000
7	Oktibbeha County	50,263	$45,500
7	Webster County	9,491	$20,000
7	Winston County	17,537	$19,500
Total			$259,708
Contribution per person			$1.50
8	Copiah County	27,395	$65,140
8	Lincoln County	34,039	$50,000
8	Madison County	107,520	$110,000
8	Rankin County	157,313	$337,000
8	Simpson County	26,540	$45,000
Total			$607,140
Contribution per person			$1.72
9	Hinds County	223,872	$1,468,663
Contribution per person			$6.56

10	Clarke County	15,453	$26,012
10	Jasper County	16,299	$34,314
10	Kemper County	9,760	$20,538
10	Lauderdale County	71,899	$139,354
10	Leake County	22,776	$18,200
10	Neshoba County	29,052	$25,200
10	Newton County	20,344	$29,500
10	Scott County	27,734	$31,000
10	Smith County	15,690	$20,840
Total contribution			$344,958
Contribution per person			$1.51
11	Adams County	29,991	$77,143
11	Amite County	12,237	$37,560
11	Claiborne County	8,820	$18,162
11	Franklin County	7,623	$18,000
11	Jefferson County	6,784	$17,952
11	Lawrence County	12,862	$22,500
11	Pike County	39,104	$89,450
11	Walthall County	13,986	$17,313
11	Wilkinson County	8,328	$10,094
Total			$308,174
Contribution per person			$2.21
12	Covington County	18,258	$35,000
12	Forrest County	74,867	$212,500
12	Greene County	12,766	$21,000
12	Hancock County	48,340	$332,159
12	Harrison County	211,672	$2,146,141
12	Jefferson Davis County	10,954	$31,000
12	Jones County	67,902	$145,000
12	Lamar County	64,755	$85,000
12	Marion County	24,215	$46,500
12	Pearl River County	55,959	$232,000
12	Perry County	12,083	$50,459
12	Stone County	19,014	$96,004
12	Wayne County	19,957	$47,500

Total			$3,480,263
Contribution per person			$5.43
14	George County	25,280	$53,000
14	Jackson County	144,597	$400,000
Total			$453,000
Contribution per person			$2.67
15	Warren County	43,957	$141,300
15	Yazoo County	30,884	$50,100
Total			$191,400
Contribution per person			$2.56
TOTAL		2,966,407	$9,112,317
Average Contribution Per Capita			$3.07

COVID-Based Funding. Service provision by CMHCs has been limited since March 2020 with only moderate improvements to date. The availability and access to services has been reduced and the methods through which services are provided have changed. There have been very limited, if any, congregate services, which are primary revenue sources with margin for CMHCs. As of May 2021, ten of the 13 CMHCs were able to receive COVID-relief funds of some sort over the last 14 months, totaling approximately $15 million. There is the possibility of additional COVID funding that will help support services and reduce negative financial impact.

Additional Revenue Information. Other issues impacting revenue noted by CMHC leadership include a lack of transportation for clients and prospective clients; the rurality of the state coupled with a severe scarcity of resources for care provision to geographically dispersed populations; complexity of the Medicaid system; diversity of county funding; a dependence on state agencies to apply for available federal discretionary grants; and disparities in government funding. Of particular concern is the dearth of psychiatrists in Mississippi. In 2017, the American Medical Association reported that Mississippi has the second lowest number of psychiatrists in the country with 6.2/100,000 citizens compared to the national average of 12.9 (Beck, Page, Buche, Rittman, & Gaiser, 2018).

The Board of Mental Health and Department of Mental Health

The Board of Mental Health is composed of nine members who are appointed by the Governor and confirmed by the Senate. The members serve staggered terms, and it is common for board members to be appointed to consecutive terms. The Board sets statewide public mental health

policy for behavioral health services for persons with mental illness, SUDs, and intellectual and/or developmental disability. Of the nine members, there must be a member of each of Mississippi's congressional districts and one of each of the following: physician, psychiatrist, clinical psychologist, and a social worker (Joint Legislative Committee on Performance Evaluation and Expenditure Review, 2014).

DMH is headed by an Executive Director that is appointed by the Board of Mental Health. DMH is responsible for certifying, monitoring, and assisting CMHCs and other service providers (Mississippi Department of Mental Health, 2021). We believe Mississippi is one of only two states where behavioral health services are administered by a free-standing state agency overseen by a board (Hogge, 2021). The current organizational structure utilizes bureaus to administer programs throughout the state. The three primary populations served are persons with intellectual and development disabilities, mental illness, and substance use disorders.

IDD Services. Intellectual and developmental disabilities (IDD) are disorders that are usually present at birth. They are usually considered lifelong chronic conditions characterized by limitations in intellectual functioning and adaptive skills, including learning, language, self-care, and capacity for independent living (American Association on Intellectual & Developmental Disabilities, 2011). Ideally, a service system provides effective, efficient service delivery that provides high-quality services and supports to persons with lifelong developmental disabilities. The foundational goals for IDD state programs are to create services and supports that allow for individuals to be treated with dignity and respect; be independent and make individual choices; participate in family, community, and work life; have opportunities to maximize their full potential; and receive outcome-based services and supports (NASDDDS, 2021). DMH operates the following programs for Persons with IDD:

- South Mississippi Regional Center (Long Beach)
- Boswell Regional Center (Magee)
- Hudspeth Regional Center (Whitfield)
- Ellisville State School (Ellisville)
- North Mississippi Regional Center (Oxford)
- Mississippi Adolescent Center (Brookhaven)

Other community-based services are provided by the 13 CMHCs and other not-for-profit community agencies. Services available include diagnostic and evaluation services, community support services, respite care, employment services, behavior interventions, and ID/DD Waiver services which may include home and community supports.

Behavioral Health Programs. DMH offers inpatient services for adults and children with serious mental health conditions and/or substance use disorders. These services are delivered through the following state-operated programs and facilities:

- Specialized Treatment Facility (Gulfport)
- South Mississippi State Hospital (Purvis)
- Mississippi State Hospital (Whitfield)
- Central Mississippi Residential Center (Newton)
- East Mississippi State Hospital (Meridian)
- North Mississippi State Hospital (Tupelo)

Other community-based services are provided by the 13 CMHCs, other DMH-certified programs (e.g. Harbor Houses of Jackson), and other behavioral health programs certified by bodies other than DMH (e.g. Brentwood Behavioral Healthcare).

SUD Treatment Programs. DMH offers substance use inpatient treatment at a limited number of hospitals for individuals with needs that are most acute and require a civil commitment. Most treatment for Substance Use Disorders (SUDs) is offered within community-based programs supported by a Substance Abuse Block Grant, federal discretionary grants, and a state three percent state tax on liquor and wine. All but two CMHCs operate their own short-term residential treatment programs and those two have affiliation agreements with other providers. Residential programs have capacity for more than 500 clients.

Priorities for Initial Stages of Review

Public mental health systems are complex and OCMHA will follow a protocol for review where the following are prioritized: (1) CMHCs that are most vulnerable regarding financial stability; and (2) services and supports that are most critical for ensuring adequate, quality services and supports in community-based settings that mitigate the need for higher, unnecessary levels of care (LOC). OCMHA plans to initially review the LOC in the most restrictive environments (inpatient programs and CSUs) and LOC that are critical for placement within services that target intervention and crisis management and reduce the risk for improper placement in more restrictive levels of care. PACT teams, ICORT, and intensive case management are programs that meet this priority.

State-administered Inpatient Services

Inpatient services for persons with serious mental illness (SMI) and SUDs are available through hospitals administered by DMH. These are the most restrictive levels of care designed for persons experiencing acute psychiatric symptoms that require hospitalization and who cannot receive adequate treatment in less intrusive LOCs and with less expensive services and supports. DMH operates four hospitals that offer inpatient psychiatric care. During FY 20, 3,687 persons were served at DMH behavioral health programs, indicating a 12% reduction in acute psychiatric service admissions (Mississippi Department of Mental Health, 2020). The capacity of each public psychiatric hospital is listed in Table 3, along with capacity pre- and post-COVID. There

has been a marked decline in available capacity and plans for capacity going forward will be reviewed.

Table 3: Inpatient Psychiatric Bed Capacity

Program	Unit	Pre-Covid Capacity	5/28/21 Current Capacity
Mississippi State Hospital	Male Receiving	58	40
Mississippi State Hospital	Female Receiving	60	28
Mississippi State Hospital	Total Adult Receiving	118	68
Mississippi State Hospital	Oak Circle Male	8	8
Mississippi State Hospital	Oak Circle Female	8	8
Mississippi State Hospital	Oak Circle Children	6	6
Mississippi State Hospital	Forensics	56	49
Mississippi State Hospital	Adult Male CDU	25	16
Mississippi State Hospital	Adult Female CDU	25	22
East Mississippi State Hospital	Male Receiving	84	68
East Mississippi State Hospital	Female Receiving	24	20
North Mississippi State Hospital	Male Receiving	25	23
North Mississippi State Hospital	Female Receiving	25	23
South Mississippi State Hospital	Male Receiving	29	27
South Mississippi State Hospital	Female Receiving	21	19

Community-based Crisis Services

The DMH FY2021-FY2023 Strategic Plan reports the following in objective 1.4: "*Strengthen the state's crisis response system to maximize availability and accessibility of services.*" The Plan explains that the desired outcomes include diverting persons experiencing severe mental health episodes from unnecessary placement in the most restrictive environments such as jails and

hospitals by utilizing Crisis Stabilization Units (CSUs), Mobile Crisis Teams, intensive case management and community crisis homes. OCMHA will evaluate current service design and provision using the *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (2020) published by the Substance Abuse and Mental Health Services Administration (SAMHSA) (SAMHSA, 2020) as a guide.

Crisis Stabilization Units. CSUs offer time-limited residential treatment services designed to serve adults with severe mental health episodes that, if not addressed, would likely result in the need for more costly, more restrictive, inpatient care. SAMHSA promotes "no-wrong door" access to mental health care and identifies the following minimum expectations for a CSU: (1) accept all referrals; (2) provide assessment and support for medical stability without requiring medical clearance; (3) offer services that address mental health and substance use crisis issues; (4) establish the capacity to respond to minor health issues with a clear pathway to more medically staffed services if needed; (5) remain staffed 24/7 with psychiatrists or psychiatric nurse practitioners, nurses, clinicians, and peer support specialists; (6) offer walk-in and first responder drop-off options; (7) infrastructure that supports 90% referral acceptance and a no rejection policy for first responders; (8) screening for suicide risk and assessments and planning when the need is indicated; and (9) screening for violence risk and comprehensive assessment and planning when clinically indicated (SAMHSA, 2020). Mississippi has 13 CSUs. OCMHA plans to examine similarities and differences between policies and practices of Mississippi CSUs and the model proposed by SAMHSA.

In the DMH FY20 Strategic Plan Mid-Year Report, DMH reported that funding was shifted to reduce reliance on institutional care that resulted in increased access to community-based services, including 44 additional CSU beds. The DMH FY20 Annual Report details that 90.45% of the 3,525 clients admitted to CSUs were diverted from state hospitals. The Mid-Year Report stated the average length of stay was 11 days. Of the 1,934 admissions, 954 were reported as involuntary and 980 were reported as voluntary (Mississippi Department of Mental Health, 2020). Table 4 below illustrates the capacity of each CSU.

Table 4: Crisis Stabilization Unit Capacity and Number Served FY20

CMHC Region	Crisis Stabilization Unit	Pre-Covid Capacity	5/28/21 Current Capacity	No. Served FY20
Batesville	CSU	16	16	432
Brookhaven	CSU	16	16	359
Cleveland	CSU	16	16	285
Corinth	CSU	16	16	385

Gautier	CSU	8	8	104
Grenada	CSU	16	16	338
Gulfport	CSU	16	16	299
Hinds	CSU	12	16	[1]Not operating in 2020
Laurel	CSU	16	16	266
Marks	CSU	8	8	140
Newton	CSU	16	16	392
Tupelo	CSU	8	8	182
West Point	CSU	8	8	97

Mobile Crisis Response Teams. Mobile Crisis Response Teams can employ face-to-face professional and peer intervention, deployed in real time, to the location of the person in crisis. Such services can reduce costs associated with inpatient hospitalization by 70 percent during the six months following the crisis event. SAMHSA identifies the following essential functions: (1) triage/screening, including explicit screening for suicidality; (2) assessment; (3) de-escalation/resolution; (4) peer support; (5) coordination with medical and behavioral health services; and (6) crisis planning and follow-up (SAMHSA, 2020). OCMHA plans to examine similarities and differences between policies and practices of Mississippi Mobile Crisis Teams and the model proposed by SAMHSA.

The first mobile crisis teams were initially developed in Mississippi during FY14. DMH describes Mississippi teams as community-based services that deliver "solution-focused and recovery-oriented behavioral health assessments." (Mississippi Department of Mental Health, 2020). These services work in partnership with local law enforcement, emergency medical services, chancery judges and clerks, and CSUs to establish a plan of care that is aligned with the unique needs of each individual. The teams are staffed with a master's level mental health therapist, community support specialist and peer support specialist. When facility-based care is needed, individuals are ideally connected through warm hand-offs. DMH currently provides grant funding for all 13 CMHC regions to provide these services. During FY20, teams responded to 36,921 calls, of which 20,322 were face-to-face and 2,590 were in conjunction with law enforcement (Mississippi Department of Mental Health, 2020).

[1] Region 9 Community Mental Health Center self-reported to OCMHA that 206 adults were served in the Hinds County CSU in FY 20.

PACT Teams. These teams target service provision for persons who have the most severe and persistent mental illnesses and require services and supports in excess of general outpatient and recovery support. The teams are funded through grants provided by DMH and consist of the following team members: team leader, psychiatrist or psychiatric nurse practitioner, two registered nurses, a master's level mental health professional, a substance use specialist, an employment specialist, a certified peer support specialist, an administrative assistant, and additional clinical personnel. (Mississippi Department of Mental Health, 2020). The DMH Annual Report of 2020 identifies 10 PACT Teams operated by eight CMHCs. Both Pine Belt Mental Health (Region 12 CMHC headquartered in Hattiesburg) and Timber Hills Mental Health Service (Region 4 CMHC headquartered in Corinth) operate two PACT teams.

ICORT. These teams are similar to PACT teams and serve the same client population but with reduced staff and higher client-staff ratios. This is reportedly in response to challenges in geographical coverage present in rural areas and associated workforce shortages. ICORT teams are made up of a registered nurse, master's level mental health therapist, peer support specialist, an administrative assistant and an optional community support specialist. Following a reportedly successful pilot program, DMH funded five additional ICORT teams during FY20. In the FY20 Annual Report (2020), DMH reported 115 persons were served through six ICORTS. More are reportedly planned for FY21.

Conclusion

This concludes the initial report for April 1, 2021, through June 30, 2021. OCMHA will now turn its attention to more detailed analyses of the services and supports most critical for addressing acute needs within the community. Data gathered to date will be utilized for the identification of CMHC regions that show indications of possible financial vulnerability. OCMHA will work in solution-focused coordination efforts with such regions to identify strengths, weaknesses, opportunities, and threats with immediate attention to follow. OCMHA will also continue work to finalize a framework for assessment of the mental health system using the eight dimensions outlined earlier in this report and development of a final draft of a quality measuring tool questionnaire. Recommendations will be made within later reports following more detailed and targeted reviews of these components of the behavioral health system.

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Appendix A

Map of CMHC Regions and Counties