Rose Isabel Williams Mental Health Reform Act of 2020

Status Report
January 1, 2022 – June 30, 2022

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 report covers the period of January 1, 2022, through June 30, 2022. Assessments performed during this period include a broad review of substance use services, accessibility, and funding. A large majority of substance use services are funded and administered by DMH and implemented via contracts or grants through individual regional mental health centers (Community Mental Health Centers or "CMHC") 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 and other non-CMHC free-standing programs. Additionally, this report also includes a brief summary of community-based programs grant funding expenditures for both mental health and substance use disorder services and an update on strategies to reduce workforce shortages at DMH-operated behavioral health programs.

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OCMHA has included the following topics for inclusion in this quarter's report:

- Summary of Community-based Grant Funding
- Services for Substance Use Disorders (SUD)

Community-based Programs Grant Funding Expenditures for Mental Health and Substance Use/Misuse Services

Community behavioral health service providers rely on multiple sources of revenue. Two primary sources are: 1) Medicaid reimbursement and 2) contracts or grants provided by state and federal agencies and administered by the Department of Mental Health (DMH). Agencies must request funds made available by state or federal sources through a written proposal process. Community Mental Health Centers (CMHCs) have a choice about whether to apply. Mental health grants are highly specialized proposals that require devotion of limited CMHC human resources within a small window of time. If a CMHC lacks grant writing skills, grant implementation experience, and available staff time, it may stretch the resources of the CMHC.

For the state fiscal year end (FYE) June 30, 2022, DMH awarded 586 contracts to service providers totaling $104,658,357. CMHCs received 434 (74%) of the number of contracts and 85% of the funding available. DMH awarded 144 contracts and grants to non-CMHC providers of mental health, intellectual and development disabilities, and SUD-focused treatment, prevention, training, administrative support, and advocacy programs.

The funding allocated to the operation of residential SUD programs consumes the largest portion of the funding for SUD services. Funding provided by DMH is intended to supplement the cost of operation rather than cover the entire cost. For this reason, CMHCs implement sliding fee scales and seek other sources of funding.

Region 9 CMHC, which serves Hinds County, does not operate a residential program for the treatment of SUD and largely utilizes Harbor House of Jackson to provide these services. Harbor House receives eight grants totaling $2,444,124. Similarly, Region 11 CMHC does not offer residential services and works collaboratively with Region 15 CMHC to meet the needs of residents. Consequently, neither Region 9 or 11 receive grants for residential services. For this reason, Region 11 does not receive a number of grants that other CMHCs receive for the provision of residential SUD services. There are many other similar caveats when examining the distribution of contracts and grants and no firm conclusions can be drawn from examining

numbers and amounts on face value. Variables that are often considered when distributing funds include geographic size, rurality, population, types of services, workforce availability, and infrastructure needed to provide services. Table 1 provides a broad view of the number and amounts of contracts or grants from DMH to community service providers and other stakeholders from which to frame discussion and examination.

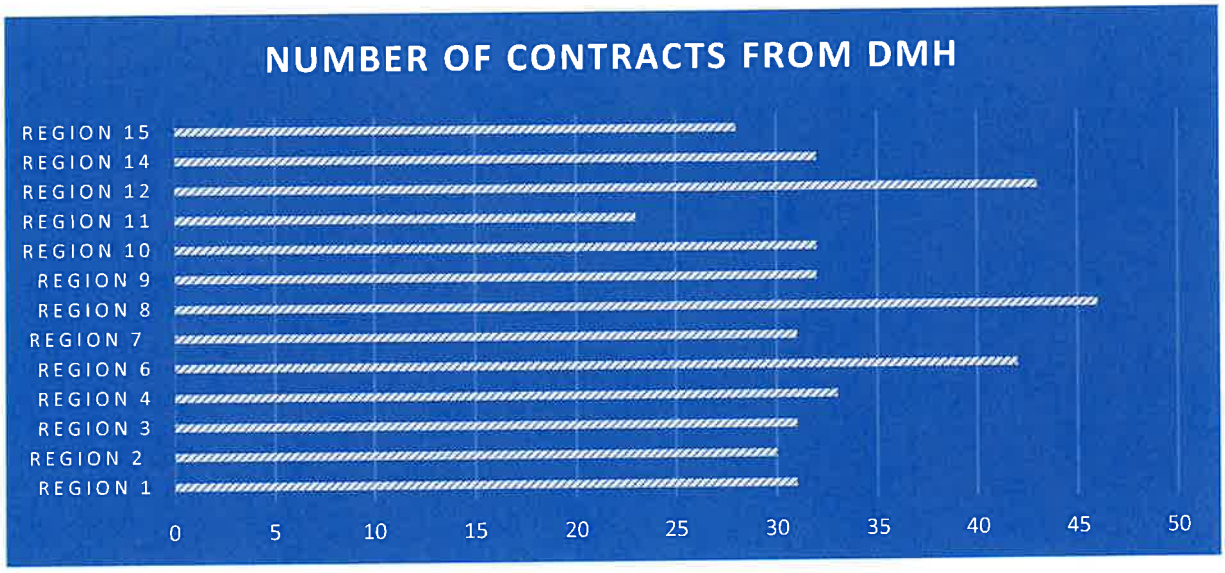
Table 1: Summary of DMH Contracts/Grants FYE 2022

Summary of DMH Contracts for the State FYE 6/30/22 by Contractor				
Contracts to Service Providers	# Counties	Region Population	Number of Contracts	Contract Amount
Region 1 CMHC	4	49,985	31	$6,883,518
Region 2 CMHC	6	178,337	30	$4,442,149
Region 3 CMHC	7	231,049	31	$5,834,339
Region 4 CMHC	5	294,762	33	$9,705,590
Region 6 CMHC	12	208,446	42	$11,223,818
Region 7 CMHC	7	172,947	31	$4,931,650
Region 8 CMHC	5	352,807	46	$9,655,961
Region 9 CMHC	1	223,872	32	$5,847,183
Region 10 CMHC	9	229,007	32	$5,853,298
Region 11 CMHC	9	139,735	23	$2,889,297
Region 12 CMHC	13	640,742	43	$12,444,254
Region 14 CMHC	2	169,877	32	$5,194,432
Region 15 CMHC	2	74,841	28	$3,776,284
Totals		2,966,407	434	$88,681,772
Harbor House of Jackson (SUD Residential Treatment Provider Used by Region 9 CMHC)			8	$2,444,124
Other contracts for treatment, prevention, consumer advocacy, etc.			144	13,532,461
Total Contracts			586	$104,658,357

Region 8 CMHC receives the largest number (46) of contracts and Region 11 CMHC receives the smallest number of contracts (23) as illustrated in Figure 1. As depicted above there is a significant number of contracts/grants awarded by DMH annually. One issue with awarding annual consolidated grants is the fact that there are multiple funding sources that cannot be pooled due to tracking expenditures and data separately. This includes specific federal grants, federal block grants, alcohol tax, healthcare funds, general funds, ARPA funds, etc. This also includes specific tracing of the grants for the remedial order core services. However, the process is time consuming for CMHCs and DMH and assessing the possibilities of awarding annual consolidated grants, to the extent appropriate, may serve as a useful endeavor.

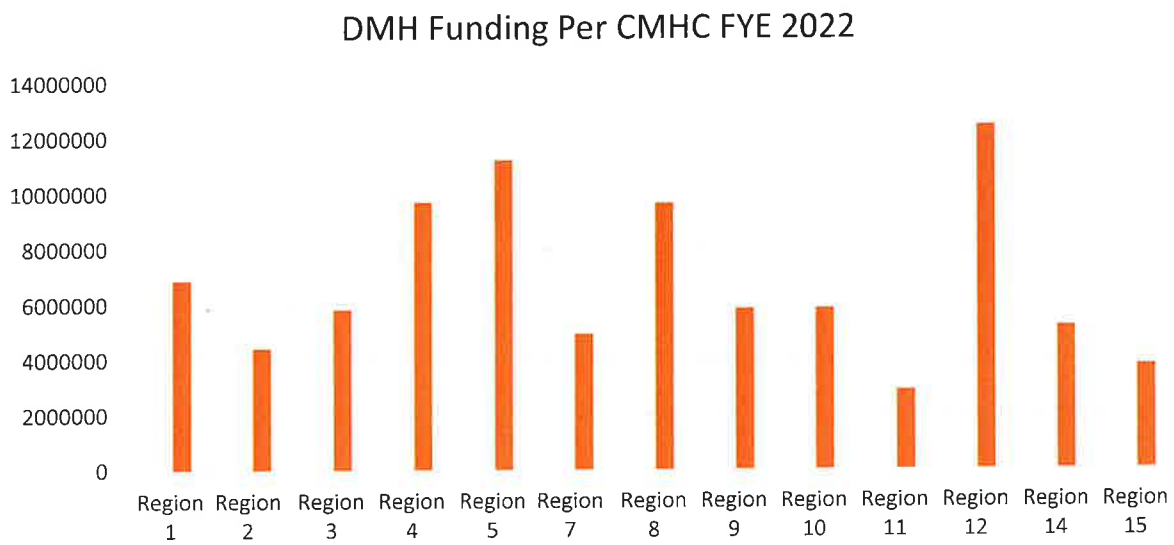
DMH performs periodic audits/reviews of providers, at least annually, so as to monitor the spending related to subrecipient grants as appropriate, necessary, and in compliance with regulations. Corrective action is usually enforced by remedy of specific performance and/or recouping of the funds, depending on the situation.

Figure 1: Number of DMH Contracts and Grants to CMHCs



Region 12, which serves the largest number of counties, receives the largest amount ($12,444,254) of funding and Region 11 receives the smallest amount ($2,889,297) as illustrated in Figure 2.

Figure 2: DMH Funding Per CMHC FYE 2022



Behavioral Health Workforce Update

In its July1, 2021 through September 30, 2021, Quarterly Status Report (https://www.dfa.ms.gov/media/bxckuuwi/september-21-quarterly-status-report-12-27-21.pdf), OCMHA reported the impact the nationwide healthcare workforce shortage is having on the behavioral healthcare system in Mississippi. Below is an update on the efforts of the State and the Department of Mental Health (DMH) to address these workforce shortages at state-operated facilities.

As of July 2022, the Mississippi State Personnel Board (MSPB) is set to implement Project SEC^2. The goal of Project SEC^2 is to "create a classification and compensation system that is fair and equitable and allows for recruitment, retention, and motivation of a qualified workforce (mspb.ms.gov, 2022)." This is anticipated to increase flexibility for DMH and improve capacity to recruit and retain skillful employees. In creation of this project, the Mississippi Legislature sought to provide funding to ensure all state employees are compensated at a minimum designated salary, based on qualifications and experience, and encourage state agencies to pursue market ranges when possible.

Some of the ranges, including Support Care Professionals (formerly referred to as Direct Care Workers), may remain lower than what is currently needed to effectively recruit in the current market. DMH has plans to address this in its FY24 budget request. For example, the minimum salary for a Support Care Professional I is $18,216 and the current market is $23,908. For Support Care Professional II, the minimum salary is $20,220 and the market is $26,538.

Considering the hourly wages currently being offered in the private sector, such as fast-food chains, it remains challenging to recruit for these essential positions within the DMH workforce which are required for licensure, certification, and effective, quality care for persons served.

As part of DMH's recent efforts to mitigate gaps in its workforce, the agency implemented several strategies to improve recruitment and retention. DMH concentrated these efforts in areas determined most significant to the continuation of services: (1) nursing and (2) direct care. DMH requested and received approval from the MSPB and the Legislative Budget Office to increase compensation for Support Care Professionals. DMH implemented the use of a 20% recruitment flex to increase the compensation for workers in this job classification. DMH also added an additional 10% shift differential for workers on the evening shift and 15% for workers on the night shift. These increases have reportedly helped with retention but have not had as much of an impact on recruitment. As discussed above, DMH plans to petition for additional funding to support an additional 10% increase to the base salary for Support Care Professionals.

To reduce gaps in nursing, DMH received approval from the MSPB to temporarily implement an increase of up to 75% Type Duty Location (TDL) pay for nurses. The nursing salaries also saw an increase in the base rate of pay due to the statewide implementation of Project SEC^2. Several DMH programs have also offered modified work schedules with minimal staffing numbers. To ensure sufficient coverage, DMH programs utilize nurses from nursing agencies that are on the Pre-Approved Vendor List. When possible, DMH programs work to ensure agency nurses return to the same service buildings each time. This effort has helped to build rapport amongst agency staff and state employees, and many of the nurses return on a regular basis. This also helps the individuals receiving services to have nursing staff familiar to them and who are familiar with the staff, environment, culture, and policies and procedures. DMH programs have also contracted with retired nurses and other nurses interested in earning an increased hourly rate versus a more traditional salary and benefits package. Each of these efforts have reportedly helped to reduce the workforce shortage. However, DMH reports that the gap remains significant and continue to seek enough interested workers to meet the needs of state hospitals and Intellectual/Developmentally Disabled (IDD) residential programs.

DMH also reports that each of the DMH-operated behavioral health programs have partnered with local WIN Job Centers as a part of DMH's collaboration with the MS Department of Employment Security. The DMH programs have held on-site job fairs, set up booths at WIN Job Centers, and are advertising all positions with Employment Security. The DMH programs have utilized on-line hiring sites such as *Indeed* and *Monster* and are also publishing employment opportunities on social media platforms. DMH has one behavioral health program testing a contract with a vendor who generates search engines and links employment opportunities with various people who show interest in the field via social media networks and various website searches. Other recruitment efforts have included drive-thru job fairs in rural locations allowing

applicants access to complete applications from their vehicle and via QR codes on mobile devices. Some DMH programs are also conducting on-site application acceptance and interviews so as not to lose potential applicants who are expressing an interest. Each of these efforts have purportedly helped with exposure but have not quite remedied the labor-related challenges in behavioral healthcare, and healthcare in general.

Substance Use Disorders (SUD)

Behavioral health services promote treatment for mental illnesses and SUDs. Reports to date have focused largely on the accessibility of services for mental health disorders. *OCMHA Quarterly Status Report for July 1, 2021 – September 30, 2021,* provided details of gaps in availability and accessibility of SUD services for the Region 11 CMHC catchment area. As such, one of the aims of this report is to provide a short primer on the treatment services in Mississippi for SUDs.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition is the American Psychiatric Association's text on mental health and offers eleven criteria, or symptoms, for SUD. There are 11 symptoms for each substance class (except for caffeine) that are used to make a substance use disorder diagnosis. The diagnosis is made along a continuum—mild (2 or 3 symptoms), moderate (4 or 5 symptoms), or severe (6 or more symptoms). (cchealth.org, n.d.). The symptoms include: (1) substance is taken in larger amounts or over longer periods than was intended; (2) persistent desire or unsuccessful effort to cut down or control substance use; (3) great deal of time spent in activities necessary to obtain substance, use substance, or recover from its effects; (4) craving, or a strong desire or urge to use substance; (5) recurrent use of the substance is resulting in a failure to fulfill major role obligations at work, home, or school; (6) continued use of substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance; (7) important social, occupational, or recreational activities are given up or reduced because of substance; (8) recurrent substance use in situations in which it is physically hazardous; (9) substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance; (10) tolerance and (11) physical withdrawal (cchealth.org, n.d.).

Many persons may experience co-occurring disorders for which they have multiple diagnoses across multiple areas (i.e., mental health disorder and an SUD). National estimates report that among adults aged 18 or older, 3.8% (9.5 million people) reported having any mental illness (AMI) and a SUD; and 1.7% (397,000) of adolescents reported having AMI and a SUD (SAMHSA, NSDUH, 2019). Table 2 illustrates the rates at which persons with a serious mental illness (SMI) report past year use compared to persons with no mental illness. National survey results indicate that about half of those who experience a mental illness during their lives will also have a SUD and vice versa and suggests that adolescents with SUDs also have high rates of

co-occurring mental illness. More than 60 percent of adolescents in community-based SUD treatment programs meet criteria for mental illness (National Institute on Drug Abuse (NIDA), 2021).

Table 2: Comparison of Past Year Substance Use

Substance	Percent Persons with SMI Reporting Past Year Use	Percent Persons with AMI Reporting Past Year Use	Percent Persons with No Mental Illness
Illicit Drugs	49.4	38.8	16.6
Marijuana	39.8	32.5	14.2
Opioids	13.8	8.8	2.5

(SAMHSA, NSDUH, 2019)

DMH is the state organization that offers certification and establishes operational standards for three areas: (1) mental health, (2) intellectual/developmental disabilities, and (3) substance use disorder treatment. DMH creates a specific annual *DMH Addictive Services State Plan* and it receives and disperses funding that is specifically dedicated to the provision of services for SUDs.

Scope of the Problem

SUD continues to be a major problem in the United States. According to the National Survey on Drug Use and Health (NSDUH), rates of past month illicit use rose from 10% of individuals 12 and older in 2015 to 13% in 2019. Fentanyl use increased by 32%, methamphetamine use by 20%, heroin use by 13%, and cocaine use by 10% (CDC). The COVID-19 pandemic increased substance use and overdose deaths substantially. There were 93,331 lethal drug overdoses in 2020, the highest number of overdose deaths ever recorded, and a 30% increase compared to 2019 (SAMHSA). Overdose rates increased by 38.4% for fentanyl, 26.5% for cocaine, and 34.8% for methamphetamines. Further, alcohol misuse is the third leading cause of preventable death in the United States (SAMHSA).

The 2019 National Survey on Drug Use and Health (NSDUH) provides the following estimates about drug use[3]:

- 35.8 million (12 and older) used illicit drugs in the past month.
- 31.6 million (12 and older) used marijuana (1.8 million adolescents age 12-17).
- 16 million (12 and older) reported heavy alcohol use in the past month.
- 2.8 million (12 and older) misused prescription pain relievers.
- 2.1 million adolescents (12-17) used illicit drugs in the past month.
- 1.9 million (12 and older) used cocaine.
- 21.6 million (12 and older) required treatment for an SUD.
- 4.2 million adults who needed treatment received it.

NSDUH (2019) provides the following estimates about drug use of adults in **Mississippi**:

- During 2017-2019, the annual average prevalence of past-year SUD in Mississippi was **6.3%** (or **154,000**), similar to both the regional average (**6.4%**) and the national average (**7.4%**).
- During 2017-2019, the annual average prevalence of past-year opioid use disorder in Mississippi was **1.4%** (or **4,000**), similar to both the regional average (**1.3%**) and the national average (**1.0%**).
- During 2017-2019, the annual average prevalence of past-year illicit drug use disorder in Mississippi was **4.5%** (or **14,000**), lower than both the regional average (**6.6%**) and the national average (**7.5%**).
- During 2017-2019, the annual average prevalence of past-year alcohol use disorder in Mississippi was **6.6%** (or **21,000**), similar to the regional average (**7.8%**) but lower than the national average (**9.8%**).
- During 2017-2019, the annual average prevalence of past-year SUD in Mississippi for persons ages 18-25 was **9.9%** (or **31,000**), similar to the regional average (**12.3%**) but lower than the national average (**14.7%**).
- During 2017-2019, the annual average prevalence of past-year marijuana use in Mississippi was **11.8%** (or **290,000**), lower than both the regional average (**14.0%**) and the national average (**16.2%**) (SAMHSA).

Marijuana is the most commonly used of all illicit drugs. For youth ages 12 -17, the average prevalence rate was 5.0% and for adults 18 years and older, average prevalence of past-year marijuana use in Mississippi was 11.8%. Of the adult population, young adults aged 18-25 reported the highest rate of past-year use (23.9%) (SAMHSA). The Substance Abuse Mental Health Services Administration (SAMHSA) reports that contrary to popular belief, marijuana can be addictive. Of persons who begin use before the age of 18, one in six can become addicted and for adults, one in ten can become addicted. The concentration of THC in marijuana is three times the concentration of THC present 25 years ago and the stronger the THC, the stronger the effects on the brain. Higher potency is likely to lead to higher prevalence rates of dependency and addiction (Know the Risks of Marijuana, n.d.).

Due to the prevalence of opioid and stimulant use disorders and related sharp increases in overdose rates, the Mississippi Board of Pharmacy, Mississippi Bureau of Narcotics, Mississippi State Department of Health, DMH, and the Mississippi Public Health Institute collaborated to establish the *Opioid and Heroin Data Collaborative (OHDC)*. The *OHDC* 2020 annual report presented the following (Health, 2022):

- There were 10.9 opioid-related overdose deaths per 100,000 persons reported to the Mississippi Bureau of Narcotics (MBN) in 2020.

- In 2020, 324 (73.1%) of the 443 suspected overdose deaths reported to the MBN were opioid related. The numbers of opioid-related deaths and total overdose deaths were **59.9% higher** and **124.9% higher,** respectively, in 2020 than in 2019.
- Emergency Medical Services (EMS) data revealed that naloxone, an opioid overdose reversal medication, was administered 2,058 times during 2020, which is 64.8% higher than the number of administrations in 2019 (1,334).

Treatment Services

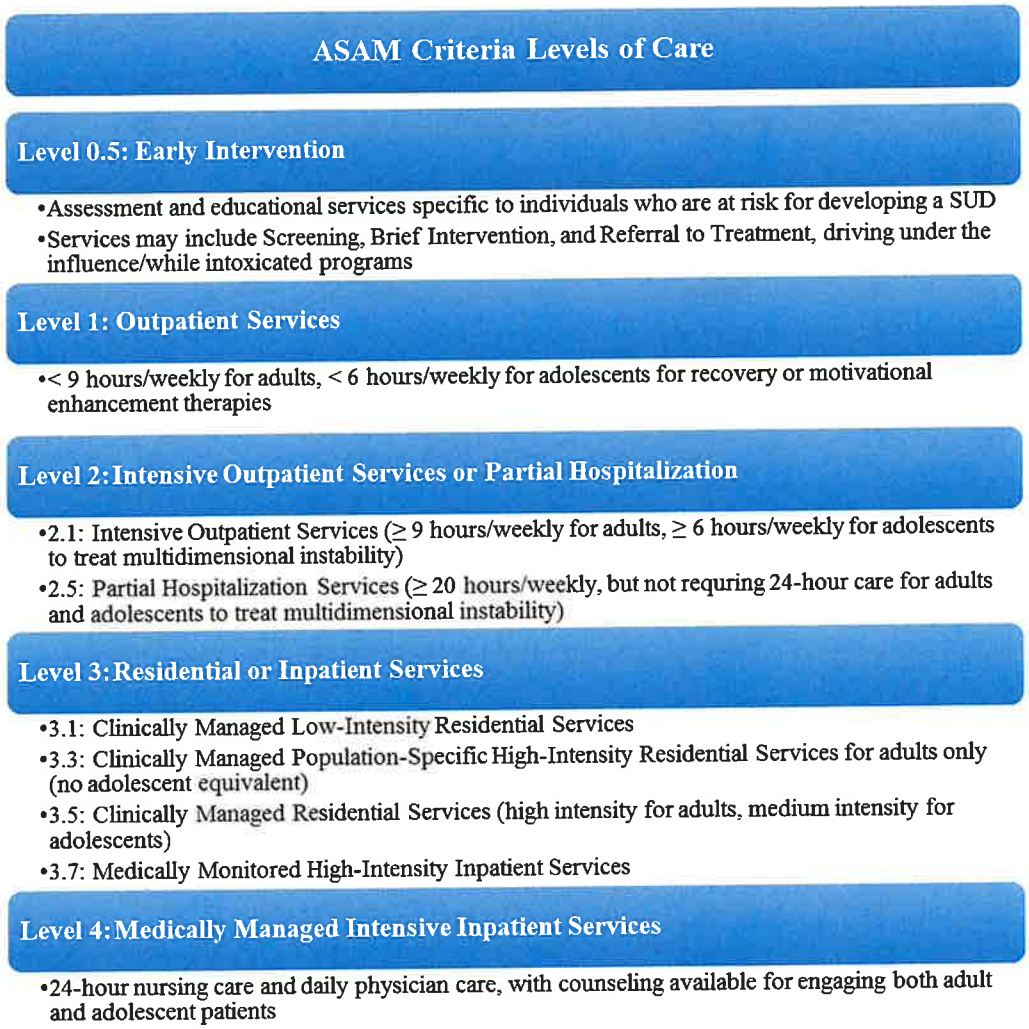
Treatment services for SUDs in Mississippi are made available through one of three avenues, which are as follows:

1. For-profit organizations
2. Not for Profit Community-based organizations
   a. Community Mental Health Centers (CMHCs)
   b. Free-standing organizations
3. DMH-administered hospital-based services (e.g., Mississippi State Hospital, East Mississippi State Hospital)

A resource directory of treatment programs certified by DMH last updated in 2019 is available at http://www.dmh.ms.gov/wp-content/uploads/2018/12/Alcohol-and-Drug-Resource-Directory-December-2018.pdf.

Levels of Care (LOC). Modalities of treatment can be delineated as LOC. Clinicians are charged with placing individuals in the most appropriate modality based on criteria established by the American Society of Addiction Medicine (ASAM). The ASAM criteria describes five broad levels of care (Levels 0.5–4) with specific service and recommended provider requirements to meet those needs. These LOC (Levels 0.5–4) span a continuum of care that represent various levels of care. A full list of the levels of care is provided in Figure 3 (Medicaid Innovation Accelerator Program).

Figure 3: ASAM Levels of Care



LOC that can be certified by DMH include:

- **Outpatient** (ASAM Level 1). General outpatient SUD treatment is appropriate for individuals whose clinical condition or environment does not require a more intensive level of care. Common treatment modalities include individual, group, and family counseling.
- **Intensive Outpatient Program (IOP)** (ASAM Level 2). Services are provided at a minimum of three hours three days per week. The 10-15-week Intensive Outpatient Program is a community-based outpatient program which provides an alternative to traditional residential treatment or hospital settings. The program is directed to persons who need services more intensive than traditional outpatient services, but who have less severe alcohol and drug problems than those typically addressed in residential treatment.

The IOP allows the consumer to continue to fulfill his/ her obligations to family, job, and community while continuing treatment.

- **Acute Partial Hospitalization Program (PHP)** (ASAM Level 2). PHP provides an intensity of treatment similar to an inpatient environment, in a less restrictive, outpatient, community-based setting that doesn't include overnight stays. This short-term, intensive, non-residential LOC offers consistent, structured treatment while maintaining the individual's usual living arrangements. Acute PHPs provide a less restrictive level of care for individuals discharged from inpatient programs, or a higher level of care when IOP is not effectively meeting the individual's needs.
- **Primary Residential** (24-hour care) (ASAM Level 3). This type of treatment offers a group living environment that provides a comprehensive program of services. It is considered a higher LOC than IOP or PHP.
- **Transitional Residential** (24-hour supervision) (ASAM Level 3). The program provides a group living environment, which promotes life free from chemical dependency, while encouraging the pursuit of vocational, employment or related opportunities. With group support, individuals acquire coping skills which enable them to become productive citizens in their community. An individual must have successfully completed a primary SUD treatment program before being eligible for admission.
- **Withdrawal Management** (Available at multiple ASAM levels**).** Withdrawal Management is the process through which a person who is physically and/or psychologically dependent on alcohol, illegal drugs, prescription medications, or a combination of these drugs is safely withdrawn from the drugs of dependence.
- **Opiate Treatment Services** (Available at multiple ASAM levels.) The services support the individual by utilizing methadone, and/or Buprenorphine while the individual participates in a spectrum of counseling and other recovery support services to assist the person with successful recovery from opiate addiction (DMH, 2019)

Other services include:

- Prevention
- Peer Support Services
- Co-Occurring Disorder Services
- DUI Diagnostic Assessment
- Emergency Services
- Support for Employee Assistance Programs
- Recovery Housing (MS Department of Mental Health)

The LOC available vary among CMHCs and free-standing programs in Mississippi. The *2022 DMH Record Guide* (DMH, 2022) requires the use of a Level of Care intake and Placement Assessment for certified SUD treatment providers. The Assessment compiles information used as part of the process for determining what service, combination of services, or LOC placement

might best meet a person's stated/presenting needs. The multidimensional information is used to match needed services and justify the need for placement in a particular LOC. One barrier is the lack of all LOCs available so while the results of an assessment may indicate the need for a particular LOC, that level may not be available in their immediate geographical area. One example is SUD partial hospitalization programs which are not available at CMHCs.

Private For-Profit SUD Treatment Centers. OCMHA reports focus on the public mental health system; however, it is important to note a number of private, for-profit programs also offer treatment for SUD. These programs have the option to be certified by DMH or can operate without DMH certification. Private programs do not often accept Medicaid reimbursements and receive payment through commercial insurance and/or self-pay. Commercial insurance often requires certification from The Joint Commission or the Commission on the Accreditation of Rehabilitation Centers (CARF). The cost can vary greatly between providers and is impacted by length of stay. DMH's *2019 Addictive Services Resource Directory (*available at http://www.dmh.ms.gov/wp-content/uploads/2018/12/Alcohol-and-Drug-Resource-Directory-December-2018.pdf) provides a list and contact information for certified providers in Mississippi. The programs listed below include some modifications (where known) that reflect changes made since the 2019 publication and therefore are not a direct reflection of the information found in the 2019 directory. Certified Intensive Outpatient Program providers (DMH, 2019) include:

- A Bridge to Recovery, Ridgeland
- Oxford Treatment Center, Etta
- Vertava Health (previously certified as Freedom Healthcare of America), Southaven
- Imagine Behavioral Health, Jackson
- Mississippi Drug and Alcohol Treatment Center, Ocean Springs
- Shephearst Meadows, LLC., Flowood
- Three Oaks Behavioral Health, Ridgeland

DMH-certified programs listed as providing adolescent Intensive Outpatient Program services include the following:

- Stonewater Adolescent Recovery Center, Oxford

Private, for-profit primary residential private centers listed in the DMH Resource Guide include:

- Oxford Treatment Center, Etta,
- Vertava Health (previously certified as Freedom Healthcare of America), Southaven
- Mississippi Drug and Alcohol Treatment Center, Ocean Springs
- Stonewater Adolescent Recovery Center, Oxford

Other private centers operate in Mississippi and are not listed in the *DMH Resource Guide* as they are not certified by DMH. Pine Grove is one such private program located in Hattiesburg

which offers programs for adolescents, adults, and has a specific program for older adults. The Estate at River Bend is located in Lucedale which serves adults.

Sober Living. Destructive living environments can be a significant barrier to recovery from SUD. Sober living programs offer a safe, drug-free, supportive environment facilitating recovery. They are not licensed or certified in Mississippi as there is no current avenue or organized body that can provide such. While there is no state licensing agency, a volunteer group has initiated work on establishing a Mississippi affiliate of the National Alliance for Recovery Residences (NARR) to offer a certification process for recovery residences that meet the national standard. Residents can often remain in sober living for months or even years as they establish financial and recovery stability. Quality services and costs can vary greatly and because homes are unregulated, consumers must identify which home fits their needs for support best.

Community-Based Addictions Services. Services for persons with SUDs are provided primarily at community-based programs. All 13 CMHC regions receive funds from DMH that supplement efforts to provide SUD services. The primary population served is persons within the designated CMHC catchment area. *See Appendix A: Map of CMHC Regions in Mississippi.* Individuals may access treatment at the program of choice, but may have to pay out-of-region fees. DMH also funds treatment centers that have a DMH certification and are not operated by a CMHC. These programs are generally referred to as free-standing programs and make up a smaller portion of the overall service system. Other for-profit and not-for-profit programs are certified by DMH and receive no DMH funding. Free-standing programs often treat persons from all areas of the state rather than from a designated catchment area.

Staffing Requirements. *Rule 11. 5 of DMH Operational Standards for Mental Health, Intellectual Disabilities, and Substance Use Community Service Providers* (DMH 2020 Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers) defines staffing requirements based on type of service. Directors, coordinators, outpatient and residential therapists must have at least a master's degree in a behavioral health-related field and either a professional license or an applicable DMH credential. Prevention Specialists must have at least a bachelor's degree and recovery support personnel must have at least a high school diploma or GED and successfully complete a substance use disorder certification program approved by DMH within thirty-six (36) months of the date of employment.

Core Services. Core services are established and defined at the discretion of DMH. The *DMH Operational Standards for Mental Health, Intellectual Disabilities, and Substance Use Community Service Providers* (MS Department of Mental Health, 2020) identify core services by population type (adult mental health, children/youth mental health, substance use services, and Intellectual/Developmental Disabilities).

DMH requires that two provider types, DMH/C and DMH/P provide core services. CMHCs fall under the DMH/C provider type and must have the "capacity to offer" core services in all counties designated as part of their catchment area. Private providers fall under the DMH/P type and must have the capacity to service either all counties that are part of the CMHC region or all counties the provider identifies as serving. DMH is responsible for assessing compliance with the provision of core services.

The core services are designed to establish a comprehensive system of care and create barriers to providers choosing to offer only the services with the largest margin of revenue ("cherry-picking"). DMH/C programs are at times provided supplemental funding to carry out the required core services via grants while DMH/P programs may or may not have access to such funding. Two examples are crisis response services and peer support services. Grants are made available to DMH/C (CMHCs) to supplement the funding of these services for persons without a reimbursement source, such as Medicaid or commercial insurance. *See OCMHA Quarterly Status Report for July 1, 2021 – September 30, 2021.*

DMH's *2020 Operational Standards, Part 2: Chapter 3: Service Options, Rule 3.1 Core Services for DMH /C and DMH/P Providers* (available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf) can be found in Appendix B and require that CMHCs (DMH/C provider type) and private providers (DMH/P provider type) provide the following core services and must have the capacity to provide those services in all counties designated in the DMH/C region or all counties identified by DMH/P providers:

a) Crisis Response Services
b) Prevention
c) Residential Services
    a. Primary Residential Services
    b. Transitional Residential Services
d) Outpatient Services/Intensive Outpatient Services
e) DUI Assessment Services
f) Early Intervention Services for HIV & AIDS
g) Peer Support Services
h) Withdrawal Management Services

Additionally, Rule 3.1 requires that Substance Use Providers designated as a DMH/P must provide the following services:

1. Outpatient Services (PHP, Intensive Outpatient, General Outpatient)
    a. Crisis Response Services
    b. Outpatient Services

    c. Peer Support Services
2. Substance Use Treatment Services
    a. Crisis Response Services
    b. Residential
        1. Primary Residential Services (Adult or Adolescent)
        2. Transitional Residential Services (Adult)
    c. Peer Support Services
    d. DUI Assessment Services
    e. Early Intervention Services for HIV & AIDS
    f. Withdrawal Management Services
3. Opioid Services
    a. Crisis Response Services
    b. Outpatient Services

Crisis services vary in terms of size and scope depending on the provider type. CMHCs receive supplemental funding to provide crisis services, which includes mobile teams, to their catchment area and serve the general public. DMH/P type providers must provide crisis response to their targeted area and must also serve the general public, including a 24-hour crisis line.

All but CMHCs 9 and 11 operate their own SUD residential treatment centers, offering services 24 hours a day 7 days a week. Region 9 works in collaboration with Harbor House of Jackson and Region 11 works in collaboration with Region 15 CMHC to provide residential LOC. Capacity of a residential program is generally measured in terms of "beds." CMHC residential alcohol and drug treatment services are not hospital-based and therefore can only offer limited, if any, medical services and are unable to provide medical withdrawal management (detox) services on-site for persons with life-threatening symptoms. Table 3 below offers the number of beds available at all CMHCs and free-standing programs as reported to OCMHA or identified in the *DMH Addictive Services State Plan* (MS Department of Mental Health). All programs offer residential treatment for both males and females. *DMH Operational Standards* require that pregnant females and IV drug users receive priority admission status. They may not be placed on a waiting list and must receive services within 48 hours.

Of persons receiving treatment in the public mental health system, DMH reports that during FY21, 4,287 individuals were served in community-based primary residential services. This number includes 3,870 adults, 84 adolescents, 104 pregnant women, 154 parenting women, and 75 men with dependent children. Also in FY21, 1,759 were served in community-based transitional residential services and 857 were served in community-based intensive outpatient programs (DMH). Approximately 672 residential beds are available in Mississippi. There are two programs that specialize in the treatment of pregnant and/or parenting women: Fairland Treatment Center operated by Region 1 CMHC and Born Free operated by Catholic Charities. Sunflower Landing, also operated by Region 1 CMHC, specializes in the treatment of

adolescents. These specialized programs offer treatment outside of their designated catchment area, serving anyone living in Mississippi. The length of stay for this residential treatment center is often longer than that of adults and may last six months or longer. Referrals are made to Sunflower Landing by all CMHCs, schools, Department of Human Services, and other interested stakeholders. Currently, there are available openings at Sunflower Landing.

DMH has reduced the number of medically managed beds available through state hospitals due to increased community-based access to care. The inpatient beds at MSH and EMSH can be reserved for those persons requiring treatment within a medical facility or are at risk of harming themselves or others. Table 3 offers the number of residential beds available per region and include beds for both primary and transitional residential treatment. Other SUD providers are available in Mississippi and utilize private commercial insurance or self-pay. These providers may seek DMH certification.

Table 3: SUD Residential Beds Capacity

CMHC	Special Populations	Beds
Region 1 CMHC	Adolescents (Sunflower Landing) Pregnant and Parenting Women	84
Region 2 CMHC		48
Region 3 CMHC		45
Region 4 CMHC		36
Region 6 CMHC		80
Region 7 CMHC		44
Region 8 CMHC		45
Region 10 CMHC		35
Region 12 CMHC		98
Region 14 CMHC		22
Region 15 CMHC		25
TOTAL Beds for CMHCs		**562**
Certified Free-Standing Programs Receiving DMH Funding		
Catholic Charities (New Beginnings and Born Free)	Pregnant and Parenting Women	24
Harbor House of Jackson	Pregnant and Parenting Women Veterans	62
Friendship Connection/Center of Independent Learning	Females Involved in Correctional System	24
TOTAL Beds for Funded Free-standing Programs		**110**
TOTAL – All Residential Beds for SUD Treatment		**672**

*CMHC numbers provided by CMHCs to OCMHA; Free Standing Program numbers were found in the DMH Addictive Services State Plan (MS Department of Mental Health)

For the CMHCs that operate residential and Intensive Outpatient Programs, in some regions one program is available for an entire region. For Intensive Outpatient services, this could mean that individuals drive a lengthy distance to attend Intensive Outpatient three days a week. This, along with other transportation issues, can serve as a barrier to accessing this LOC. Persons may then lean towards no treatment or treatment in a higher LOC (i.e., residential program or chemical dependency unit) than is warranted. No CMHCs offer Acute Partial Hospitalization services for SUD or Opiate Treatment Programs (OTPs) that utilize Methadone. All OTPs in Mississippi are administered by certified, for-profit organizations.

Crisis Residential Units (CRUs). DMH's *2020 Operational Standards, Part 2: Chapter19: Crisis Services, Rule 19.6 Crisis Residential Services – Crisis Residential Units* (available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-

Standards-5-19-22-1.pdf) states that CRUs are time-limited treatment services which provide "psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances." A primary goal is to prevent civil commitment and/or longer-term inpatient psychiatric hospitalization through observation and support aimed at reducing acute symptoms and distress. The *DMH Operational Standards* also state that "Crisis Residential Services may be provided to children/youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness (DMH 2020 Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers)." As such, individuals with SUD alone are not candidates for admission to a CRU, but if an individual has a co-occurring disorder (e.g., mental illness and a SUD), they may be eligible for services. The *DMH Operational Standards* state that drug toxicology screening must be performed, and substance use counseling must be provided. No particular screening instrument for SUD is required for persons presenting in crisis. DMH reports that if the individual responds with affirmation that they are seeking treatment for SUD or if they report a history of SUD, the assessor then employs the use of SUD *Level of Care Intake and Placement Assessment*.

DMH-Operated Chemical Dependency Programs. Mississippi State Hospital (MSH), located in Whitfield, Mississippi, and East Mississippi State Hospital (EMSH), located in Meridian, Mississippi, offer hospital-based SUD treatment. This level of service can only be accessed through a civil commitment. DMH reports MSH generally has 50 adult beds available for SUD treatment; however, the capacity was recently reduced to 15 males and 20 females due to staff shortages. EMSH has 25 adult, male beds which opened in July 2021 and there are plans to increase the number of beds to 50. (*See OCMHA Quarterly Status Report for July 1, 2021 – September 30, 2021* for information regarding behavioral health workforce shortages available at https://www.dfa.ms.gov/media/bxckuuwi/september-21-quarterly-status-report-12-27-21.pdf).

In FY21, the average wait time for substance use treatment services at MSH was approximately 60 days. This is an increase from approximately 36 days in FY20, or 67%. The increase wait time has been affected by the COVID-19 pandemic, which has resulted in fewer beds available for use at MSH and in the community, as providers took efforts throughout the year to comply with social distancing and additional pandemic-related guidance. While the wait time has increased, the diversion program was successful at diverting 224 people throughout FY21 from inpatient care at MSH to community providers.

Currently, there are eight males waiting for admission and 53 females waiting for admission for SUD treatment at a state hospital. DMH reports the average wait time for an individual to receive care at EMSH is seven days and the average wait time at MSH is 31 days for females and 81 days for males. DMH staff reports that the two hospitals work together to ensure wait lists are

managed in a manner that offers the least wait time and EMSH regularly services male clients who were originally on the wait list for MSH.

For FY21, MSH reports treating 275 individuals with an average length of stay of 41 days at a cost of $564 per person (DMH). In part due to high cost of hospital-based services, community-based services are made widely available for persons who are appropriate for LOC below that of medically managed intensive inpatient. This structure offers persons the ability to access services close to home in their communities.

Bed Registry System. DMH launched a bed registry on April 1, 2020. The registry lists available beds for residential treatment. DMH manages admissions to available beds at DMH-operated programs, which include State Hospitals and IDD facilities. DMH cannot manage admissions or place individuals in beds available at CMHCs or other community-based providers, including CSU and Crisis Diversion beds. Instead, admission criteria for placement in residential programs is solely at the discretion of the CMHC or other community-based provider who operates the program.

The registry provides a daily portal conveying only information regarding patient flow and a password-protected website available to:

- State Hospitals;
- IDD facilities; and
- CMHCs that includes CMHC mobile crisis teams and crisis stabilization units (CSUs).

Updates are entered manually once per day (Morrissette, 2021). This system can be particularly useful when working to place pregnant women and IV drug users within timeframes specified by the SABG. During COVID-19, the Mississippi Department of Health activated a limited system of care (SOC) plan that included the management of transfers for critical care services that could not be accommodated by the normal ICU referral processes. Hospitals were required to report bed status to MSDH daily and Mississippi MED-COM directed patients to available beds (Dobbs, Craig, Berry, & Hall, FY 2022).

While the DMH bed registry has been a good resource, it does not currently extend to chancery clerks and first responders. These persons may have to call various programs seeking availability of a bed, which could create a barrier to access. Of the 23 states with bed registries, 14, including Mississippi, utilize web-based search engines. Fourteen of the 23 states with a bed registry allow access to emergency departments, two allow access to jails, and one allows access by the police (Morrissette, 2021).

Maneuvering the SUD treatment system and the LOCs can be complex. Facilities do reach capacity and must maintain a wait list periodically. Time can be of the essence when working to

place individuals in care, particularly when working to comply with placement of a pregnant female in the appropriate LOC within 48 hours of request.

Medication Assisted Treatment. As the opioid epidemic has led to record overdoses, states have responded with an increase in the availability of medication assisted treatment (MAT) for persons with an OUD. MAT is considered the primary evidence-based tool for the treatment of OUD. The drivers of increasing access have been the SAMHSA-funded State Opioid Response (SOR) grant, Certified Community Behavioral Health Clinic (CCBHC) grants, and policy changes at the Division of Medicaid which increased access to FDA-approved medication. In response to this ongoing need, DMH has partnered with the Mississippi Public Health Institute (MSPHI) to provide training and increase capacity of the workforce of community-based providers to improve access to MAT.

Funding

Funding Process. Funding is allocated to community-based providers by DMH through a Request for Proposals (RFP) and/or Funding Continuation Applications (FCAs). The RFP/FCA addresses any special requirements mandated by DMH and originating funding sources and provides accountability. According to DMH's Bureau of Behavioral Health Services' Alcohol and Drug Services State Plan (2022), applications for funding are reviewed by DMH staff, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP/FCA, (2) the applicant's provision of services' compatibility with established priorities, and (3) availability of resources. Most grants are operated through fee for service (FFS) and are reimbursed for services provided at a standard rate that is often based on Medicaid rates for the same or similar services.

Medicaid Reimbursement. Nearly all services made available for mental health outpatient services are also covered for Medicaid beneficiaries with SUD diagnoses. SUD treatment services typically covered by Medicaid include individual and group therapy; MAT; Intensive Outpatient Programs and Partial Hospitalization Programs in an outpatient setting in a hospital which provides psychiatric services or a free-standing psychiatric hospital and withdrawal management services provided in a hospital.

SUD Residential Treatment programs certified by DMH as a community or private mental health center can be reimbursed by Medicaid for some services provided, such as individual therapy, group therapy, and peer support while the beneficiary is in residential treatment. Medicaid is unable to reimburse for some room and board due to the Institute for the Mentally Disabled (IMD) exclusion which disallows payment in facilities with more than 16 beds. This exclusion applies to state hospitals as well and no room and board services provided at these programs can be reimbursed by Medicaid. Some states have successfully pursued a 1115 Waiver to address the IMD exclusion. Mississippi has not applied for an 1115 Waiver to date.

Medicaid reimbursement for evidence-based services is also available for treatment for persons with Opioid Use Disorders (OUDs) provided by OTPs or Office-Based Opioid Treatment providers (providers must have specialized waiver to prescribe Buprenorphine products). Medicaid currently covers all FDA-approved medications for OUD. Some of the medications require prior authorization which is granted within 24 hours if an individual meets criterion. Most persons seeking SUD treatment at CMHCs are not Medicaid recipients. They are more often reliant on self-pay and supplements from available grants.

Federal Funding. The Governor of the State of Mississippi has the authority to designate the state agency responsible for the administration of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) in Mississippi. On August 16, 2021, Governor Tate Reeves designated DMH as the agency to apply for the SABG and to sign all assurances and submit all information required by federal law and the application guidelines for the remainder of his term (MS Department of Mental Health). *See Appendix C: August 16, 2021 Correspondence from Governor Tate Reeves Designating DMH as the SABG Applying Agency.* The structure of DMH changed recently from a stand-alone Bureau of Alcohol and Drug Services to a broader Bureau of Behavioral Health Services. This Bureau is comprised of five divisions. Three of the five divisions offer services related to the development, implementation, and supervision of community-based treatment for SUD: Division of Prevention, Division of Treatment, and the Division of Recovery and Peer Support (MS Department of Mental Health).

DMH administers the public system of SUD assessment, referral, prevention, treatment, and recovery support services in Mississippi. Provision of services is accomplished by contracting to support community services provided by regional commissions and/or by other community-based organizations. The *Bureau of Behavioral Health Services, Addictive Services State Plan 2022-2023* explains that DMH is mandated to:

(1) establish standards for the state's alcohol/drug prevention, treatment, and recovery support programs;
(2) assure compliance with these standards;
(3) effectively administer the use of available resources;
(4) advocate for and manage financial resources;
(5) develop the state's human resources by providing training opportunities; and
(6) develop an alcohol/drug data collection system (MS Department of Mental Health).

For FY 2021, SAMHSA awarded $49,936,049 to the State of Mississippi for the treatment and prevention of SUDs (SAMHSA, 2022). Of this amount, DMH was awarded $35,008,674 in SABG formula-based funding which includes supplemental funding of $11,173,892 made available by the American Rescue Plan (SAMHSA, FY 2021 Substance Abuse Prevention and Treatment Block Grant American Rescue Plan Supplemental Awards). Block grants are made

available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity (SAMHSA, FY 2021 Substance Abuse Prevention and Treatment Block Grant American Rescue Plan Supplemental Awards). These grants are noncompetitive, formula grants mandated by the U.S. Congress and require an annual application. The objective of the annual SABG is to help plan, implement and evaluate activities that prevent and treat substance abuse and promote public health. Populations targeted by the SABG include pregnant women and parents with dependent children, persons at risk for contracting HIV, and intravenous drug (IV) users.

SUD Prevention Services. OCMHA found no sources of state funding currently provided directly for the prevention of SUD. By federal mandate, at least 20% of the SABG must be spent on the prevention of SUDs (SAMHSA). States have the flexibility to use data to decide how to spend funds based on their unique needs but within guidelines specified by SAMHSA's Center for Substance Abuse Prevention. DMH distributes this federal funding to community partners who offer prevention services at the community level. Evidence-based prevention strategies have a return on investment of about $18 for every $1 invested. These savings commonly are derived from reduced medical costs, increased productivity at work, reduced crime and an overall better quality of life (NASADAD). Programs are encouraged to use evidence-based programs and strategies. Prevention programming can be effective across all ages, but programs often target youth and utilize various strategies for impacting perceptions of harm and behaviors (use). Most prevention programming targets youth. In fact, each CMHC Region has a prevention coordinator and many of the CMHCs are involved in the schools. Strategies include substance use information dissemination, educational curriculums, and environmental strategies. Environmental strategies are aimed at changing policies or practices that can affect large sections of the population such as indoor smoking laws and minimum age laws for the purchase and consumption of alcohol and tobacco products. Many regions have one prevention coordinator responsible for covering the entire regional catchment area. CMHC regions vary in geographic size and a map for reference is provided in *Appendix A: Map of CMHC Regions in Mississippi.*

As part of the implementation of SAMHSA's State Opioid Response (SOR) grants, DMH has established a media campaign that aims to educate the public on the dangers of opioid and heroin use, reduce overdose deaths and facilitate connection to treatment resources. The initiative uses multiple social media platforms and maintains an active website. The initiative is entitled *StandUp Mississippi* and offers specific resources for employers, employees, and persons interested in training in Narcan, an overdose reversal agent. *Standup Mississippi* is an initiative led by DMH and includes a partnership with the following federal and state agencies: Board of Pharmacy, Bureau of Narcotics, Department of Human Services, Department of Public Safety, Federal Bureau of Investigation, and Drug Enforcement Administration. More information can be found at https://standupms.org/.

The *2019 DMH Addictive Services Resource Guide* identified the following certified prevention agencies: Alcohol Services Center, Inc.; Alcorn State University, DREAM of Hattiesburg, Mallory Community Health Center, Inc.; Metro Jackson Community Prevention Coalition; Mississippi Drug and Alcohol Treatment Center; Mississippi State University; National Council on Alcoholism and Drug Dependence, and Vicksburg Family Development.

DMH frequently applies for and is awarded additional funding from federal discretionary grants. DMH was recently awarded an additional $14,927,275 in discretionary funding from SAMHSA. Discretionary grants are generally competitive and vary in size and scope as determined by SAMHSA. States have the option to apply for these funds. Discretionary grants are often categorized by purpose, such as research, training, services, construction, and conference support.

Application for federal discretionary dollars requires significant capacity in terms of human resources, time commitment and skill. Following the grant award, SAMHSA monitors progress through a combination of financial and programmatic requirements. Each state is assigned a SAMHSA government project officer (GPO) and grants management specialist (GMS) to work collaboratively to monitor performance through reviews of reports and correspondence, audit reports, and site visits. The terms and conditions of each grant is provided on a written "Notice of Award" which identifies the specific reporting requirements of the grant. Federal reporting requirements include:

- Annual Federal Financial Report (FFR)
- Progress Reports
- Federal Funding Accountability and Transparency Act (FFATA)
- Federal Awardee Performance and Integrity Information System (FAPIIS)

(SAMHSA, Post-Award Reporting Requirements, 2022)

Discretionary grants are generally distributed to the community, with five percent or less of the award allowable for the agency's administrative support and operations. The length and start dates of the grants vary from project to project. The largest discretionary grant in terms of award size is the State Opioid Response (SOR) Grant ($7,161,998) which aims to increase access to medication-assisted treatment for the treatment of opioid use disorder (OUD); reduce unmet treatment need; and reduce overdose-related deaths through the provision of prevention, treatment and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs) and stimulant misuse and use disorders (SUD), including cocaine and methamphetamine (SAMHSA, State Opioid Response Grants). A detailed list of discretionary grants can be found at https://www.samhsa.gov/grants-awards-by-state/MS/2021. Table 4 describes federal funding DMH receives that offers support for SUD services.

Increasingly, states use their public health institutes across a wide range of project tasks from

grant-writing and grants administration to grants management and evaluation, among other services. The DMH Bureau of Addiction Services often works in collaboration with the MSPHI to administer temporary discretionary grants. The flexibility, efficiency, and responsiveness facilitate achievement of meeting tight grant deadlines and strict funding parameters. Further, leveraging such a partnership likely increases the capacity of the state to bid successfully for competitive federal grants. In fact, federal government agencies now strongly and regularly encourage Departments of Mental Health, along with State Departments of Health, to enlist public health institutes as a key partner in grants submitted. One specific advantage is the ability of a partnering agency to quickly hire temporary contract employees to work the designated life of a grant allowing the state to avoid hiring employees into state pins.

Table 4: Federal Funding for SUD

Grants	Amount
Formula Funding	
Substance Abuse Prevention and Treatment Block Grant (SABG)	$35,008,674
Discretionary Grants	
SUD Prevention	$1,632,264
SUD Treatment	$13,295,011
TOTAL for Discretionary Grants	$14,927,275
TOTAL FEDERAL FUNDING for FY 2021	**$49,936,049**

(SAMHSA, 2022)

State Funding. Since 1977, a three percent tax is levied on liquor and wine sales in Mississippi for the purpose of providing treatment for alcohol use disorders. The annual amount of funding received is directly correlated with the volume of liquor and wine sold in Mississippi. The FY2020 amount made available by this tax was $10,214,944 (MS Department of Mental Health). Table 5 illustrates the single source of state funding. When needed, the funds made available can serve as required match for federal funding. In addition, general funds dollars are appropriated by the Legislature to provide funding for substance use treatment beds at Mississippi State Hospital and East Mississippi State Hospital.

Table 5: State Funding for SUD

State Funding for FY2021	Amount
Three percent alcohol tax	$10,214,944

Other Sources of Funding. Community-based organizations also can apply directly to federal, state and local governmental agencies for funding. Applying for federal grants requires significant capacity in terms of time and skilled human resources. The capacity needed varies substantially from program to program.

OCMHA Recommendations: Based on information gathered for this report, OCMHA has the following recommendations:

Issue: Information About Available Residential LOC	
Time is of the essence when seeking care for SUDs as a crisis has often occurred leading to the need for immediate care at the residential LOC. When chancery clerks and first responders are seeking access to treatment, information is not readily available about the availability of beds at residential programs. Excessive time and energy may be spent calling various treatment centers to determine who has an available bed.	
Background	DMH supports a robust residential treatment system for SUDs (672 beds across the state) in collaboration with community-based organizations such CMHCs. However, it is not uncommon for programs to be full with a waiting list while another center has available beds. DMH launched a bed registry April 1, 2020, which allows state hospitals, IDD facilities, and CMHCs to view availability through a password-protected website. This system can be particularly useful when working to place pregnant women and IV drug users within timeframes specified by the SABG. Admission criteria for placement in residential programs is solely at the discretion of the CMHC or other community-based provider who operates the program. Access to the bed registry does not currently extend to chancery clerks and first responders. These persons may have to call various programs seeking availability of a bed, which could create a barrier to access. States are beginning to implement smart phone applications as a means of increasing availability of this information to stakeholders to increase access and reduce barriers.
Recommendation 1:	Implement a technological solution for making the bed registry system available to chancery clerks and first responders needing to place individuals in appropriate LOCs.
Issue: Expanding Formalized Partnerships and Collaboration.	
There is evidence of efforts in agencies working collaboratively with other state agencies that have similar vested interests in reducing the prevalence of SUD and associated negative outcomes. There is opportunity to formalize partnerships and collaborations in written agreements which may serve to increase the level of communication, collaboration and activities and lessen chances for duplication of services.	
Background	SUD disorders are costly and impact many social service systems and state agencies. Where there is substance misuse and abuse, there is associated crime, maladaptive health conditions, employment issues, housing challenges, family disruptions, and emergency situations. Each agency likely has goals and objectives that target an SUD-related problem(s). As such, agencies that have a vested interest in SUD-related social problems can benefit significantly from formalized, collaborative partnerships that may serve to reduce duplication and

	synergize efforts. Financial, human and other resources could be maximized to increase positive outcomes of efforts.
Recommendation 2	Increase formal collaborative agreements between treatment service providers and stakeholders who benefit from access to available SUD services (MS Bureau of Narcotics, Child Protective Services, Emergency Departments, First Responders, Drug Courts, MS Department of Health, MSPHI…).
Issue: Explore Increased Intensive Outpatient Services	
DMH requires that clinicians place individuals in the most appropriate modality based on criteria established by the American Society of Addiction Medicine (ASAM); however, the LOC are not available in all communities. If the results of a treating clinician's assessment identify Intensive Outpatient LOC as the level needed, there may not be an available program within the patient's nearby community. In some regions one program is available for an entire region. This could mean that individuals drive a lengthy distance to attend Intensive Outpatient three days a week. With this, along with other transportation issues, persons may then lean towards no treatment or treatment in a higher LOC (i.e., residential program or hospital-based) than is warranted.	
Background	The 10-15-week Intensive Outpatient Program is a community-based outpatient program which provides an alternative to traditional residential treatment or hospital settings. The program is directed to persons who need services more intensive than traditional outpatient services, but who have less severe alcohol and drug problems than those typically addressed in residential treatment. The IOP allows the consumer to continue to fulfill his/ her obligations to family, job, and community while continuing treatment.
Recommendation 3	CMHCs and DMH should consider ways to expand the accessibility of Intensive Outpatient treatment programs.
Issue: Expanding Access to Partial Hospitalization LOC	
DMH requires that clinicians place individuals in the most appropriate modality based on criteria established by the American Society of Addiction Medicine (ASAM). While Partial Hospitalization LOC for the treatment of SUD is provided by private providers, it is not currently available at CMHCs. If the results of the assessment identify Partial Hospitalization LOC as the level needed, there are no available programs located at a CMHC.	
Background	CMHCs currently do not provide Partial Hospitalization Programs. Clinicians are charged with placing individuals in the most appropriate modality based on criteria established by the American Society of Addiction Medicine (ASAM). Assessments performed at admission are required to facilitate placement in the correct LOC at the initiation of treatment. Partial Hospitalization Programs provide an intensity of treatment similar to an inpatient environment, in a less restrictive, outpatient, community-based setting. This short-term, intensive LOC offers consistent, structured treatment while maintaining the individual's usual living arrangements. Acute PHPs provide a less restrictive level of care for individuals discharged from

	inpatient programs, or a higher level of care when IOP is not effectively meeting the individual's needs.
Recommendation 4	Since Partial Hospitalization LOC is provided by private providers not currently available at CMHCs, DMH should explore the need for and support required to establish partial hospitalization services at CMHCs for the treatment of SUD.

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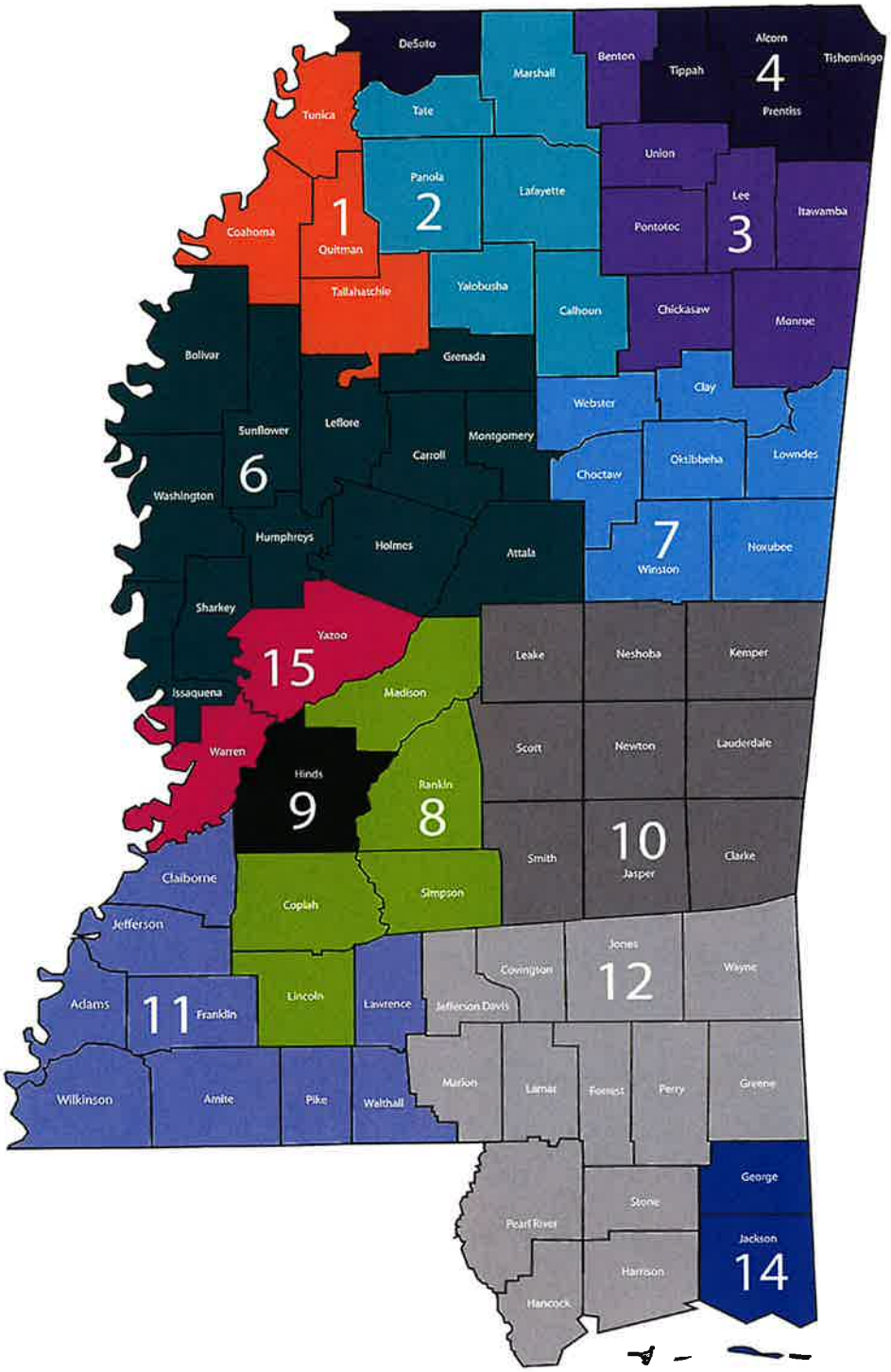
Appendix A

Map of CMHC Regions in Mississippi


DeSoto
Marshall
Benton
Tippah
Alcorn
4
Tishomingo
Prentiss
Tunica
Tate
Union
Panola
2
Lafayette
Lee
3
Itawamba
Coahoma
1
Quitman
Pontotoc
Tallahatchie
Yalobusha
Calhoun
Chickasaw
Monroe
Bolivar
Grenada
Webster
Clay
Sunflower
Leflore
Montgomery
Carroll
Choctaw
Oktibbeha
Lowndes
6
Washington
Humphreys
Holmes
Attala
7
Winston
Noxubee
Sharkey
Yazoo
15
Leake
Neshoba
Kemper
Issaquena
Madison
Warren
Scott
Newton
Lauderdale
Hinds
9
Rankin
8
Smith
10
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Jones
12
Covington
Wayne
Adams
11
Franklin
Lincoln
Lawrence
Jefferson Davis
Marion
Lamar
Forrest
Perry
Greene
Wilkinson
Amite
Pike
Walthall
George
Stone
Pearl River
Jackson
14
Harrison
Hancock

Appendix B

Core Services for DMH /C and DMH/P Providers

Part 2: Chapter 3: Service Options

Rule 3.1 Core Services for DMH/C and DMH/P Providers

A. Community Mental Health Centers (DMH/C) operated under the authority of regional commissions established under MCA Section 41-19-31 et seq. and DMH/P must provide all the following core services and have the capacity to offer these services in all counties designated in the DMH/C region or all counties identified by (DMH/P) providers.

B. Services for Substance Use Providers designated as (DMH/O) or (DMH/P) must include the following:

1. Outpatient Services (PHP, Intensive Outpatient/General Outpatient)	
(a) Crisis Response Services	111
(b) Outpatient Services	137
(c) Peer Support Services	279
2. Substance Use Treatment Services	
(a) Crisis Response Services	111
(b) Residential	
(1) Primary Residential Services (Adult or Adolescent)	231
(2) Transitional Residential Services (Adult)	230
(c) Peer Support Services	279
(d) DUI Assessment Services	317
(e) Early Intervention Services for HIV & AIDS	305
(f) Withdrawal Management Services	334
3. Opioid Services	
(a) Crisis Response Services	111
(b) Outpatient Services	137

Source: Section 41-4-1 of the *Mississippi Code, 1972, as amended*

Rule 3.2 Intellectual/Developmental Disabilities Services

A. Services available through the ID/DD Waiver include:	Page
1. Crisis Intervention	125
2. Crisis Support	127
3. Day Services – Adult	167
4. Community Respite	170
5. Prevocational Services	171
6. Job Discovery	174
7. Supported Employment	176
8. Supervised Living	197
9. Behavioral Supervised Living	201
10. Medical Supervised Living	205
11. Host Homes	211
12. Supported Living	214
13. Shared Supported Living	218
14. Support Coordination	287
15. In-Home Respite	291
16. In-Home Nursing Respite	292
17. Behavior Support	295

18. Home and Community Supports 299
19. Transition Assistance 301

B. Services available through the IDD Community Support Program include:

1. Day Services-Adult 167
2. Prevocational Services 171
3. Supported Employment 176
4. Supported Living 214
5. Targeted Case Management 287

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Appendix C

August 16, 2021 Correspondence from Governor Tate Reeves Designating DMH as the SABG Applying Agency

State of Mississippi

TATE REEVES
Governor

August 16, 2021

Odessa F. Crocker
Formula Grants Branch Chief
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
Rockville, MD 20857

Dear Ms. Crocker:

I designate the Mississippi Department of Mental Health as the state agency to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG) in Mississippi. I designate the Executive Director of the Mississippi Department of Mental Health, Wendy Bailey, to apply for the block grant and to sign all assurances and submit all information required by Federal law and the application guidelines. These designations are effective throughout the remainder of my term as Governor.

If you have any questions, please contact Ms. Bailey or Jake Hutchins, Deputy Executive Director Community Operations, at (601) 359-1288 or email jake.hutchins@dmh.ms.gov.

Sincerely,

Tate Reeves
Governor

Post Office Box 139, Jackson, Mississippi 39205 • Phone (601)359-3150 • Fax (601) 359-3741