Introduction

Overview and purpose

In 2011 the U. S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. Their review found that the State of Mississippi failed to meet its obligations under Title II of the American with Disabilities Act (ADA), 42 U.S.C. § § 12131-12134, and its implementing regulations, 28 C. F. R. pt. 35, by unnecessarily institutionalizing individuals with mental illness or developmental disabilities in public and private facilities and failed to ensure that they are offered a meaningful opportunity to live in integrated settings consistent with their needs. Specifically, DOJ found the state in violation of Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with mental illness and developmental disabilities receive services and supports in the most integrated setting appropriate to their needs.

Following receipt of DOJ's findings, the Mississippi Legislature appropriated $10 million in FY 2014 and $16.1 million in FY2015 to the Department of Mental Health (DMH) to expand the provision of community-based services for individuals with serious mental illness and for individuals with Intellectual and Developmental Disabilities. In addition, DMH retained the Technical Assistance Collaborative (TAC) in the spring of 2014 to develop a strategic plan to expand permanent supportive housing (PSH) in Mississippi for persons with mental illness and other disabilities and high need populations. TAC is a national nonprofit organization that provides policy leadership, technical assistance and consultation for many federal, state and local government agencies on such topics as mental health, substance use, developmental disabilities, homelessness, and affordable housing systems, and is recognized for its expertise in working with states to facilitate the development of systems designed to support community integration for persons with disabilities.

As part of the strategic planning process, TAC reviewed various community-based housing sites and interviewed a wide spectrum of key informants about the housing needs of individuals with disabilities in Mississippi. Just prior to issuing the final report, *A Statewide Approach for Integrated Supportive Housing,* the Mississippi Office of the Attorney General and DOJ signed an agreement (August 29, 2014) designed to provide a framework for the parties to reach a resolution on all issues. Among the commitments in the letter, the State of Mississippi agreed to provide expanded services for adults with mental illness and people with intellectual and developmental disabilities.

Per the letter, the State retained TAC to "…provide technical assistance to the State at the State's direction and in collaboration with the Department of Justice…," and to perform "assessments of existing services, guidance on program development, and recommendations related to program improvement," with a focus on the following:

- The development of permanent supportive housing and the dedicated permanent supported housing fund;
- The transition of individuals with serious mental illness from institutions to the community using permanent supported housing; and
- The implementation of intensive supports for individuals with serious mental illness in permanent supported housing, including Assertive Community Treatment.

TAC has continued to provide technical assistance and support for the development and funding of PSH. In addition, staff has conducted a thorough assessment of the services and system that support adults with serious mental illness and addictive disease. The purpose of this report is to inform negotiations between the State of Mississippi and DOJ. This report presents TAC's findings based on culmination of extensive information gathering and analysis, and identifies several recommendations to increase the availability of and accessibility to services and housing in Mississippi for individuals with serious mental illness and intellectual and developmental disabilities.

Our review is consistent with various reports identified throughout this document that have reviewed and ranked Mississippi's mental health system at or near the bottom on many measures. It is clear that there are many well intentioned and committed individuals working in the system, but until there is collective ownership of the problem, many individuals with mental illness will continue to fall through the cracks and end up in costly state hospitals or jails, or live in homelessness or substandard housing. It is our opinion that responsibility and accountability for successful reform of Mississippi's public mental health system must not fall solely on the shoulders of DMH, and must be acknowledged and shared by all involved, including DOM, State housing, transportation, employment agencies, the Mississippi Legislature, county government, CMHCs and other providers, and consumers and families.

Methodology

Mississippi DMH engaged TAC to conduct an assessment of Mississippi's adult behavioral health system and to identify recommendations to assure ready access to an array of services needed for individuals to live successfully in permanent supportive housing. Per the Augusts 29 letter between Mississippi and DOJ, the adult services assessment was commissioned concurrently with a similar assessment of Mississippi's behavioral health system for children and adolescents. To perform the children's assessment, TAC subcontracted with the University of Maryland, Institute for Innovation and Implementation (The Institute) with system expertise in successfully serving children with significant behavioral health needs in community settings. Since both assessments involved many of the same agencies and stakeholders, TAC and The Institute staff parceled out a number of on-site visits and conducted analysis of both children and adult services at these locations.

The adult services needs assessment was conducted between October, 2014 and February, 2015. TAC's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Division of Medicaid (DOM) and DMH participant characteristics, claims, and encounters; and

2) An in-depth qualitative analysis of all relevant documents, site visits and interviews with stakeholders, adult consumers, family members, providers, associations, advocacy groups, and state personnel.

TAC applied a multifaceted approach to gathering information, including conducting a literature review, synthesizing quantitative and qualitative data, interviewing stakeholders and key informants, and applying TAC's extensive expertise analyzing similar data in other states. Specifically, methods included:

- Data analysis of populations served, service utilization, Medicaid claims, quality data, and other system indicators from DOM and DMH.
- National and state document reviews.
- Site visits to state operated services and Community Mental Health Center (CMHC) programs.
- Key informant interviews.
- CMHC surveys.

The state provided quantitative data from DMH and DOM. Data from DMH included state operated services utilization, crisis services utilization, Uniform Reporting System reports and DMH certified providers. Community Mental Health Center data included selected adult services utilization and funding information.

DOM provided five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014) which coincided with implementation of managed care in the State. This data included Medicaid enrollment, utilization, place of service and expenditures for behavioral health services.

TAC reviewed documents and literature from a variety of sources, including DMH, DOM, and the Department of Health as well as the CMHCs. The State identified and provided numerous legislative and other reports, policy, quality, and procedural documents for review. CMHCs provided program literature, service descriptions and budget information. In total, XX number of state documents were provided or researched from DMH, DOM and DOH; CMHCs provided XX additional sources of information. These documents offered details on system indicators and issues being tracked by the programs, and policy and quality issues identified and monitored by leaders in various state agencies as well as the CMHCs. A listing of documents provided or researched can be found in Attachment XX.

A significant part of the qualitative analysis involved engaging and interviewing a broad array of stakeholders. TAC conducted interviews with over XX people individually and in small focus groups. These individuals included adult consumers and families, state personnel, DMH Board members, Medicaid Coordinated Care Organizations (CCOs) and the Utilization Management/Quality Improvement Organization (UM/QIO), CMHC executive leadership and direct care staff, advocates, and associations. State officials and DOJ identified an initial group of key informants for each of the identified topic areas and this initial group of informants identified additional subject matter experts. Interviews were confidential and were not conducted in the presence of DMH or DOM staff with the exception of the CCO and Central Mississippi Residential Center interviews. A complete listing of Adult Services key informants can be found in Attachment XX to this chapter. Please note that names of consumers and

some family members are not included in order to maintain their confidentiality as service recipients; however, they are included in aggregate numbers.

Interviews with key informants took place in person, telephonically and via onsite-visits. The first onsite-visit occurred from October 21st to October 23rd and included meetings with state leadership from DMH, DOM, mobile crisis and stabilization providers, advocates and CMHC leadership. The second site-visit took place from November 10th to November 13th and consisted of visits to a statewide sample of behavioral health service providers, including state hospitals, CMHCs, crisis services, psychosocial rehabilitation programs and mental health and Alcohol and Drug (A&D) residential programs. In all, TAC and The Institute staff visited XX total providers and XX provider sites located throughout the state. Please refer to the map below and Attachment XX for a complete listing of the providers visited. The themes that emerged from these meetings, interviews and reviews of written materials are included throughout this report.

TAC used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and analysis of Mississippi data to develop a list of actionable recommendations for Mississippi to implement. These recommendations include:

1. *Assuring an Effective Array of Services for Adults.* Recommendations in this chapter focus on implementing and financing an effective array of covered services across Medicaid and DMH, focusing on services and supports necessary to help individuals succeed in permanent supportive housing. This chapter identifies methods to enhance services available under Mississippi's Rehab option, including Program for Assertive Community Treatment teams (PACT), mobile crisis response and stabilization services, Psychosocial Rehabilitation, Community Support Services and Peer Support services based on national models, as well as adding the Evidence-based practice of Supported Employment to the continuum.
2. *Expanding Capacity/Enhancing Services.* This chapter addresses the impact of inadequate funding for behavioral health services, including disparities in access to Mississippi's Core Services for Adults; limitations of service provision; workforce shortages; workforce competencies; and explores provisions to expand and improve provider capacity.
3. *Improving and Monitoring Quality*. This chapter identifies quality priorities, and necessary processes and measures to promote quality across adult behavioral health services.
4. *Promoting interagency collaboration*. This chapter addresses governance structures, interagency priorities and processes to build an effective system that eliminates barriers, builds bridges and promotes access to life in the community with Recovery supports.
5. *Defining the role for institutional care*. This chapter identifies several factors contributing to Mississippi's over-reliance on state hospital services, and provides a framework for establishing a clear role and expectations for state operated services within a continuum of care for adults with behavioral health disorders.

State context

Mississippi is a predominantly rural state, the fourth most rural state in the country with about 51 percent of its population living in a rural area (compared to 19 percent nationally).[1] Only three cities in the state have populations in excess of 50,000 including Jackson, the state capitol; Gulfport, a center for tourism along the Coast; and Hattiesburg, home of the University of Southern Mississippi. According to information from Northeast Mississippi Area Health Education Center at Mississippi State University, as of April 2012, approximately 2.1 million Mississippi residents reside in a mental health professional shortage area with an estimated 1.1 of those residents considered "underserved."[2] In addition to its rural nature, the state is one of the poorest in the nation, ranking 4th in Poverty. The unemployment rate among adults is about 9 percent, the third highest in the country[3] and 32 percent of high school students do not graduate on time, the second highest rate in the country[4]. The state ranks nationally at or near the bottom for most health indicators.[5]

The state continues to recover from the devastation incurred by a number of natural disasters, most notably Hurricanes Katrina and Rita. Tornadoes have also devastated communities, including one within the past year which destroyed one of the region's only mental health programs. Even with Federal assistance, the need to re-build its economy has taken precedence for the state, compromising its ability to strengthen its community-based health and social services. Yet these same crisis incidents have increased demand for these community services which were already woefully underfunded.

In FY 2013 Mississippi's public community mental health system served 73,244 adults, ages 18 and older; 88 percent met the federal criteria for Serious Mental Illness. [6] In 2013, Mississippi's mental health authority, the Department of Mental Health (DMH), spent about $163 million on mental health services for children and adults, compared to a national average of $190 million. Nationally, state mental health authorities (SMHAs) spent an average of 71.1% of their total budgets on community-based programs for adults and 25.7% of their total budget on state mental hospitals. Conversely, DMH spent 77% of its mental health budget on state mental health hospitals for adults and 21% on community services; only seven other states in the country have similar spends. Mississippi was one of only 8 states that spent more on state hospital services than community-based care in 2013. Mississippi ranked 49th lowest in the country for community-based mental health expenditures for adults.[7]

---

[1] U.S. Census Bureau. [2010]. Urban, Urbanized Area, Urban Cluster, and Rural Population, 2010: United States.

[2] Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437

[3] U.S. Department of Labor, Bureau of Labor Statistics (BLS). Local Area Unemployment Statistics, Annual Average, "Unemployment rates for states, [2013]

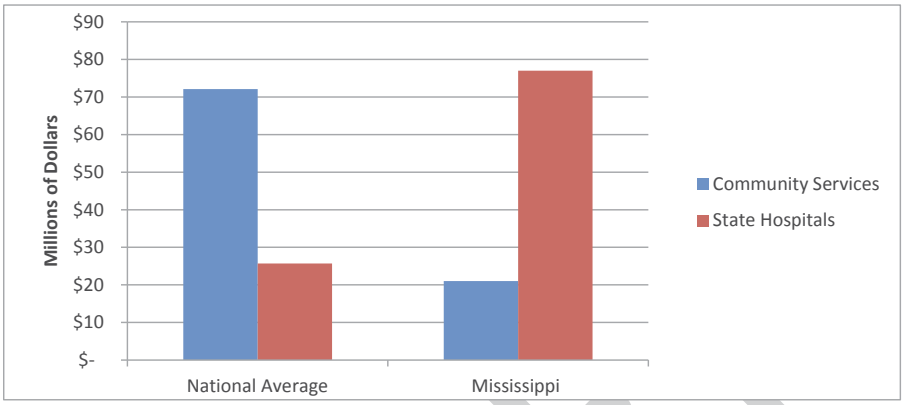
[4] Population Reference Bureau, analysis of data from the U.S. Department of Education.
U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), State Dropout and Completion Data, accessible online at http://nces.ed.gov/ccd/drpcompstatelvl.asp

[5] http://cdnfiles.americashealthrankings.org/SiteFiles/AnnualDownloads/Americas%20Health%20Rankings%202014%20Edition.pdf

[6] http://www.samhsa.gov/data/sites/default/files/URSTables2013/Mississippi.pdf

[7] http://www.nasmhpd.org/docs/TAC%20Assessment%20PDF%20Report/Assessment%2010%20-%20Expenditures.pdf

Figure 1: State Mental Health Authority- Controlled Mental Health Expenditures at State Psychiatric Hospitals and Community-Based Programs for Adults



In addition to DMH funding, the Division of Medicaid is a significant financer of community-based care for individuals eligible for Medicaid health insurance. In FY 2014, Medicaid fee-for-service and managed care claims accounted for $64.3 million for outpatient (non-hospital) mental health services for adults ages 21 and older. Mississippi has strict Medicaid eligibility criteria for adults, though people with a serious mental illness who meet Social Security Disability criteria are eligible. Nationally, states spend on average $16,643 per Medicaid enrollee with a disability while Mississippi spends $10,450.[8]

Key State Agencies

The Department of Mental Health and the Division of Medicaid are the predominant programs responsible for administering and funding Mississippi's behavioral health system for adults. While other agencies interact with the behavioral health system and helped to inform findings and recommendations throughout this report, the scope of this study did not include an assessment of behavioral health services administered by agencies other than DMH and DOM.

Department of Mental Health

Mississippi's public behavioral health system is administered by the Department of Mental Health (DMH). DMH is organized into three components: The Board of Mental Health, the DMH Central Office, and DMH-operated Programs and Community Services Programs. The Board of Mental Health is responsible for governing DMH and includes a physician, a psychiatrist, a clinical psychologist, a social worker with relevant experience, and citizen representatives. The Central Office oversees administrative functions of DMH and implements policies set forth by the State Board of Mental Health. The DMH Central Office is divided into six bureaus, including the Bureau of Administration, the Bureau of Mental

[8] http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?state=MS

Health, the Bureau of Community Mental Health Services, the Bureau of Alcohol and Drug Services, the Bureau of Intellectual and Developmental Disabilities, and the Bureau of Quality Management.

Established within the Bureau of Community Services, DMH's Division of Adult Services has the primary responsibility for developing, implementing, expanding, and monitoring a comprehensive continuum of services for adults with serious mental illness, as well as to assist with the care and treatment of persons with Alzheimer's disease/other dementia. The Division also allocates financial resources and coordinates the establishment of programs. Some federal and state funds for direct community mental health services for adults are provided by grants between the DMH and the regionally organized CMHCs and/or other public or private non-profit mental health service providers.

The components of the behavioral health delivery system include: DMH-operated programs, regional community mental health centers (CMHCs), and other nonprofit/profit service agencies/organizations that provide community services and/or institutional services.

State-operated programs.

The Department of Mental Health administers and operates five behavioral health programs for adults. Four of the programs provide inpatient services for adults with serious mental illness and substance abuse; and one program provides supported living and crisis stabilization:

- East Mississippi State Hospital in Meridian provides 120 acute, intermediate and continued psychiatric care beds; and 25 alcohol and drug treatment beds.
- Mississippi State Hospital in Whitfield provides 315 acute, intermediate and continued psychiatric care beds; and 80 alcohol and drug treatment beds.
- North Mississippi State Hospital in Tupelo provides 50 acute psychiatric care beds.
- South Mississippi State Hospital in Purvis provides 50 acute psychiatric care beds.
- Central Mississippi Residential Center in Newton provides 48 supervised living, 24 supported living and 16 crisis stabilization beds.

In addition, Mississippi State Hospital and East Mississippi State Hospital provide Nursing Home Services, and MSH provides Medical/Surgical Hospital Services and Forensic Services. The majority of state hospital psychiatric beds are identified for acute psychiatric care, though MSH and EMSH provide continued care beds. Mississippi ranks first in the nation for the number of state psychiatric inpatient beds, adjusted per total population.[9]

Table 1: 2010 Public Psychiatric Beds/100,000 Total Population

State	Number of beds 2010	2010 beds/ 100,000 total population	State ranking per capita (highest to lowest)
Mississippi	1,156	39.0	1
South Dakota	238	29.2	2
New York	4,958	25.6	3
Kansas	705	24.7	4
Alabama	1,119	23.4	5

[9] http://tacreports.org/tables

Delaware	209	23.3	6

Table 2: Rate of Admissions for SMI Population

State	State Psychiatric Hospital Admissions 2012 (1)	State SMI Rate (2)	Adults w/ SMI (3)	Rate of SMI admitted to state psychiatric hospitals (4)		
US	125,321	3.97	9,637,318	1%		
MS	3,073	4.69	105,671	3%		
GA	7,034	3.66	274,722	2.50%		
LA	1,964	3.56	124,896	1.50%		
NC	2,676	3.92	296,508	0.90%		
IA	793	4.12	97,592	0.80%		
OR	821	4.6	141,300	0.58%		
PA	1,125	4.06	408,390	0.30%		

1. SAMHSA URS Tables; Most recent 2012

2. NSDUH 2014 Rate of SMI

3. Based upon US Census Adult population Data (2013)

4. Number of admissions divided by number of SMI in state.

Table 3: Number of Adult Admissions and Average Length of Stay in Days by State Hospital, 2014

Facility	Admissions		Ave Length of Stay	
	MH	A&D	MH	A&D
East Mississippi State Hospital	589	316	41	26
Mississippi State Hospital	1,093	754	99.03	37.21
North Mississippi State Hospital	475	N/A	34 (acute only)	N/A
South Mississippi State Hospital	632	N/A	27 (acute only)	N/A
	T = 2,789	T = 1,070		

As stated in Section 159 of the Mississippi Constitution, admission to a state hospital for both mental health and substance abuse treatment beds is dictated by order of a Chancery Court Judge. There are 20 Chancery Court districts and 49 Chancery Court judges in Mississippi. The number of chancery judges per district ranges from one to four. Chancery Court judges are selected in non-partisan elections to serve four-year terms. While it is the role of the Court to determine if an individual meets the standard for involuntary mental health commitment, the court may or may not engage the regional behavioral health authority in an attempt to divert an individual from inpatient care.

Community Mental Health Centers

The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community

mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars, forming the backbone of Mississippi's public, community behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental illness, and emotional and substance use disorders
- Reduce the number of initial admissions to the state hospitals
- Prevent re-admissions through supportive aftercare services

CMHCs operating under the authority of regional commissions must provide the following core services for adults in each county in the CMHC's entire catchment area:

Table 4: Medicaid and DMH funded behavioral health services for adults

Outpatient Therapy
Community Support Services
Psychiatric/Physician Services
Emergency/Crisis Services
Inpatient Referral
Pre-Evaluation Screening for Civil Commitment
Peer Support Services
Targeted Case Management Services
Support for Recovery/Resiliency Oriented Services
Substance Abuse Outpatient
Prevention Services
Primary Residential Treatment Services

Private behavioral health providers

The use of private providers in the public behavioral health system outside of CMHCs is very limited in Mississippi. A few private mental health providers are certified by DMH and receive DMH funding to provide targeted services for adults or services in targeted geographic areas. Two providers offer Core services in Jackson, and another offers Core services to individuals with Cognitive impairments. DMH also contracts with private for acute care partial hospitalization and specialized mental health holding beds.

Division of Medicaid

The "Mississippi Administrative Reorganization Act of 1984," established the powers and responsibilities of the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program. The duties of the Division of Medicaid Agency are set out by State and Federal legislation and the approved Mississippi State Plan and include setting regulations and standards for the administration of the Medicaid programs, with approval from the Governor, and in accordance with the Administrative Procedures Law.

DOM's Office of Mental Health oversees mental health programs and it is comprised of two divisions, the Mental Health Services Division and the Special Mental Health Initiatives Division. The Mental Health Services Division is responsible for:

- Acute freestanding psychiatric facilities
- Community/private mental health centers
- Outpatient mental health hospital services
- Pre-admission screening and resident review
- Psychiatric units at general hospitals

The Special Mental Health Initiatives Division administers:

- Federally qualified health centers and rural health clinics
- In-patient detoxification for chemical dependency
- Intellectual disabilities/developmental disabilities
- Psychiatric services by physician or nurse practitioner

In 2011, Mississippi implemented a coordinated care program for Mississippi Medicaid beneficiaries called the Mississippi Coordinated Access Network (MississippiCAN) under a 1932(a) State Plan Authority. Managed by the DOM Bureau of Coordinated Care, MississippiCAN employs two coordinated care organizations (CCOs), Magnolia Health Plan and United Healthcare that offer the full range of Medicaid benefits to enrollees, including all outpatient mental health services and excluding inpatient hospital services, Waiver services, and transportation services. MississippiCAN is available in all 82 counties, and covers 45 percent of Medicaid beneficiaries, primarily adults.

Services that are not covered under MississippiCAN (inpatient hospital services, Waiver services, and transportation services) are provided through Mississippi Medicaid's traditional fee-for-service system. Both non-managed care enrolled Medicaid beneficiaries and fee-for-service benefits are managed by eQHealth Solutions (eQHealth), which serves as the state's Utilization Management and Quality Improvement Organization (UM/QIO). The eQHealth conducts prior authorizations and quality of care reviews for beneficiaries enrolled and services covered in the fee-for-service system.

As of December 31, 2014, there were 340,326 adults enrolled in Mississippi Medicaid. Of this total, 185,307 (54%) were enrolled in the state's managed care program and 155,019 (46%) were enrolled in the traditional fee-for-service program. Of those adults enrolled in Medicaid, 33,626 used some type of behavioral health service in SFY 2014. This number is a combined number across both managed care and fee for service thereby representing some duplication in the count of total utilizers.

Assuring an Effective Array of Services

The Affordable Care Act (ACA)" recognizes that prevention, early intervention and when necessary, treatment of mental and substance use disorders are an integral part of improving and maintaining overall health. In articulating how these conditions should be addressed in a transformed and integrated

system, in 2010 SAMHSA released a brief describing a "good and modern" mental health and substance abuse system[10]. As outlined in this brief, a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. A modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.

The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a "good" and "modern" system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented in order to maintain individuals in their communities. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidence-informed practice; the system should recognize the key role of community supports with linkage to housing, employment, etc. A good system should improve the lives of Mississippians.

Table 5: Elements of a Good and Modern System for Adults

Health Homes	Prevention / Wellness	Engagement	Outpt/ Med Mngmt	Community Supports	Intensive Supports	Other Living Supports	Out of Home Res	Acute Intensive	Recovery Supports
Access to medical care Care coordi-nation	SBIRT Warm Lines Relapse Prevention Wellness Recovery	Motivational Interviewing Assmnt Service Plng Including Crisis Plng	Individual EBTs Group Therapy Family Therapy Med Mngmt Pharma-cotherapy Med Assisted Therapy	Psychosocial Rehab (skill-Building) Case Mgmt Supported Employment Permanent Supported Housing Recovery Housing	PACT Partial Hospital Programs Intensive Outpt Intensive Case Mgmt	Trans Recreation Social Activities Interact Commun Technolog Devices	Crisis Residence Crisis Stabilization A&D Res Treatment	Mobile Crisis 24/7 Crisis Phone Line 24-hr Clinical Care	Peer Support Recovery Coaches Peer Run Drop In Self Directed Care

Expanding Beyond Core Services

Core services provide a system framework but are not comprehensive, flexible, intensive or accessible enough to meet the needs of many individuals with SMI, and do not include the service array as identified by SAMHSA's Good and Modern System. As a result, the insufficiency of core services to

[10] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf.

support adults in PSH and other integrated community settings results in an over-reliance on crisis oriented and institutionally-based care. In addition to the Core Services, CMHCs are able, but are not required, to request certification from DMH, to provide more comprehensive services to address additional needs of adults they serve. Additional non-core services may include acute partial hospitalization, psychosocial rehabilitation services, supported employment and Community Living Services. Every CMHC provides psychosocial rehabilitation services and about half of the CMHCs provide Community Living Services; No CMHC provided Supported Employment for adults with serious mental illness. In order for individuals to live successfully in their communities, TAC asserts that the array of services should be expanded in order to provide the necessary supports for individuals with mental health disorders and addictive disease regardless of which county/region they reside. Among the services that should be expanded include the following.

Program of Assertive Community Treatment

In an effort to create readily accessible treatment for individuals with frequent utilization of inpatient and Crisis Services, in 2011 DMH approved Regions 6 and 15 to re-allocate existing funds to create Program of Assertive Community Treatment (PACT) teams. Each region created the multi disciplinary team, had team members participate in extensive training and has conducted repeated Fidelity reviews. These initial teams have experienced marked reductions in inpatient utilization and increased residential stability with persons served. However, the Teams were both established in rural areas of the state, creating multiple challenges to implementing, delivering and sustaining the full benefits of the service. Neither team is operating at full capacity, based on the Rural PACT team staff to client ratio. The inability or unwillingness of the CMHCs to expand the territory served by the Teams has resulted in underutilization of the service, with less than 50 persons supported by each team. Team Leaders report that attempts to engage individuals, especially persons with significant histories of substance abuse, often are unsuccessful. In addition, it is reported that adults with distrust of agencies are not willing to have Team members in their homes at the level of frequency required for Fidelity. The low numbers of persons served, coupled with the costs associated with the multidisciplinary team (Region 6 identified that the agency must pay $100/hour for psychiatric time, including travel time to and from Memphis and Jackson), equates to a cost per person of about $14,000 annually which is within the “reasonable” range of cost for PACT teams.

Several rural states and communities have encountered similar challenges in implementing PACT teams. However, states including Washington, Oklahoma and South Carolina have been able to operate teams with smaller caseloads to accommodate the travel time required in a rural territory. These teams have also maintained a focus on co-occurring mental health and substance use disorders through treatment team meetings and cross-training team members.[11] [12] [13]

While PACT services may be more costly than other community-based behavioral health services in Mississippi, Figure 2 below illustrates several outcomes for individuals served by the original PACT

[11] http://nashp.org/sites/default/files/Washington_ACT_Porter_09.pdf

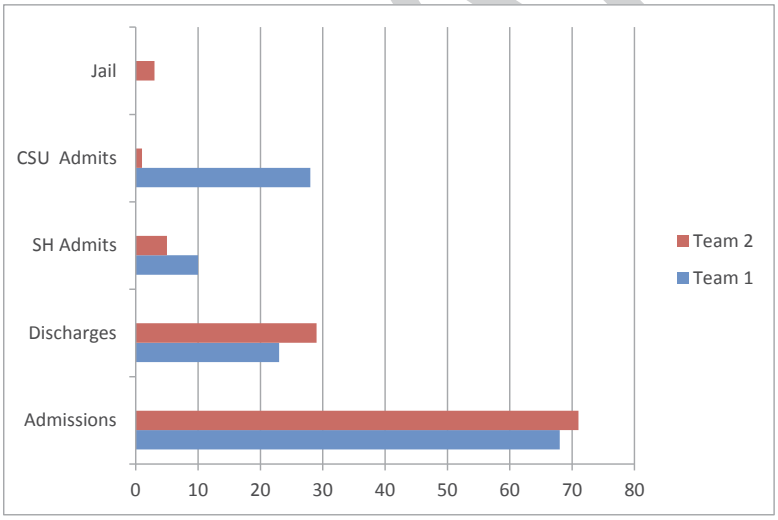
[12] http://www.ncbi.nlm.nih.gov/pubmed/7641003

[13] http://www.red-rock.com/Services/PACT.html

teams. The over-arching benefit of PACT is the team's holistic approach to working with individuals to meet their needs. A good example is the teams' work in assisting recipients to obtain benefits. Team members reported working with several adults who, as a result of multiple transitions between the state hospital and the community, were never successful in being determined eligible for Medicaid. Once assigned to PACT, teams worked with the state hospital staff to initiate applications for benefits, and followed the process through into the communities where the individuals were discharged. Reportedly, most if not all of the individuals were found to be Medicaid eligible, providing coverage for ongoing behavioral health services including medications. By maintaining the stability achieved from their hospitalization, the teams report noticeable reductions in re-admissions.

Building on this momentum, DMH has secured and targeted additional funding to expand services. In December, two new teams supported with DMH grants began providing services in the Hattiesburg and Gulf Coast Regions. In February a third team started providing services in the Jackson Metro area, and a fourth team will start serving individuals in DeSoto County as soon as all Team members are hired. Since these teams are in more populated areas there should not be issues with operating at full capacity. In January, the Division of Medicaid identified funding for DMH to add two more PACT teams which will expand the service into a total of 8 regions. These additional teams should be targeted to serve regions where integrated community housing efforts are being developed.

Figure 2: Legacy PACT Team Outcomes



Commented [SS1]: Cyndi and Diana – this chart reflects the data that Andrew sent me a few weeks ago. It doesn't really make the case however, of the impact of PACT because there are no 'bars" depicting each measure pre-PACT. Is that info available?

Mobile Treatment and Services

Statewide accessibility to PACT teams is important for individuals who need and are willing to participate in this intense level of support, but the service is not intended for everyone. Medication

management and individual, group and family therapies are available within each region for individuals and families who need less intensive treatment and are able to get to the CMHC. However, since the termination of Mental Illness and Monitoring Services in June, 2012, Mississippi lacks an interim level of support for individuals who need individualized treatment and support but who lack the ability, or are unwilling, to make regular visits to a provider. Small teams with a licensed professional able to monitor medication compliance, access to a psychiatrist/physician or Advanced Nurse Practitioner for consultation, a CSS and/or Peer Support Specialist, and mobile capacity to deliver services in the home or other community-based locations would fill a gap in the current continuum. These mobile teams would not include the number of professionals or frequency of contacts as required for fidelity to PACT, and would make the service more affordable. DMH would need to establish eligibility criteria and standards for services including mobility; the service isn't intended to be merely a less costly alternative with reduced requirements but should be structured to deliver appropriately defined treatment and support.

Innovative approaches that bridge the service gap between PACT teams and clinic services have proven successful in other states include the Chronic Users System of Care in Mendocino County, CA[14]; the Mobile Medication Program for Patients with Mental illness in Lawrence County, PA[15]; and the ASPIN Network Community Health Worker Program in Indiana[16].

Strengthening Psychosocial Rehabilitation

Prior to 2012, many individuals with serious mental illness participated in daily activities at "clubhouse" programs operated by the CMHCs. The services reportedly lacked skill-building and evidence-based approaches, focusing more heavily on socialization. However, four regions reported investing considerable resources into obtaining national certification of their clubhouses with a focus on supported employment. As a result of on-site reviews and audits, the Division of Medicaid determined that the services were not being delivered in accordance with the state plan amendment (SPA) and discontinued funding of clubhouse services in 2012. With the loss of Medicaid reimbursement and no DMH funding to support the service, clubhouses were forced to close and were replaced with Psychosocial Rehabilitation services (PSR).

The SPA indicates that reimbursable PSR services include "…skill-building groups focusing on social skills training, coping skills, daily living skills and time and resource management." Two separate services are used to facilitate development of these skills – Psychosocial Rehabilitation and Day Support Services. The Table below identifies important characteristics of the two services.

Table 6: Comparative Analysis of Psychosocial Rehabilitation and Day Support Services

Service	Purpose	Activities	Staff Qualifications	Med FFS Rate

[14] http://www.raconline.org/success/project-examples/783

[15] http://www.raconline.org/success/project-examples/742

[16] http://www.chwcrs.org/

Psycho Soc Rehab	Participants learn about their illnesses, how to manage symptoms, and the importance of adhering to their treatment plan.	Clinically focused and employ the evidence based practice of Illness Management and Recovery Structured and goal-oriented	Services provided under the supervision of a licensed Master's level professional. Program Director or MH Therapist must be on site at least 5 hours/week	$3.87/15 min. unit Or $15.48/hr
Day Support Service	Participants develop skills necessary for independent living	Focus on social skills development, activities of daily living and time and resource management	At least 1 staff with a Master's degree and prof license; Others under the supervision of a Master's level licensed professional	$2.70/15 min. unit Or $10.80/hr

This rate differential provides incentive for the CMHCs to provide more PSR services than Day Support. By creating separate services, individuals with SMI are not benefiting from the full array of skill-building opportunities. PSR programs should focus on 'living, learning, working and socializing'… essential domains for community inclusion.

In addition, skill acquisition developed through facility-based PSR programs is limited if the service participants are not given the opportunity to apply them "in vivo." The lack of an off-site, mobile PSR service prevents individualized training and practice in real life situations for recipients. This is especially important for individuals moving into integrated community living. Based on 2014 Medicaid fee-for-service and managed care claims data, PSR services were only provided "In home" to 6% and 7% of service recipients respectively, illustrating the lack of mobile psychiatric rehabilitation services.

The change from clubhouses to PSR programs was reported as positive for many service recipients, but not so positive for others. Participants attending various PSR programs who were interviewed indicated they were benefiting from the group sessions and topics, as well as the increased structure of the service. Program directors pointed out, however, that attendees have shifted and that some individuals with more chronic conditions have stopped participating in PSR due to their inability to sit through the focused group discussions or their lack of interest in the topics. Absent alternative opportunities for meaningful daily activities and social interaction, many of these individuals are isolated at home, or spend their days walking the streets in their communities to pass the time.

Peer Run Drop–In Centers

In Mental Health America's s 2015 report on the State of Mental Health in America, Mississippi's mental health system ranked at or near the bottom of states on several measures including access to care.[17] Ironically, in spite of its rural nature, the state ranked 4th highest in the nation for Social Connectedness.[18] The Clubhouses may not have provided a robust Medicaid reimbursable service but it appears that they may have provided an opportunity for individuals with serious mental illness to make and meet with friends.

Isolation is one of the key contributors to decompensation for individuals with serious mental illness and addictive disease. As Oxford University researcher Tom Burns describes what is known to be effective in

[17] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
[18] Ibid.

keeping people with serious mental illness in the community, "… insuring… a person's social life is stabilized reduces the rate of relapse substantially." [19] The elimination of Clubhouses without an alternative opportunity for socialization and connectedness has created a void in the continuum of supports for adults with serious mental illness in Mississippi.

Peer run drop-in centers are an evidence based practice recognized by SAMHSA[20]. The benefits from Peer run services are two-fold: Individuals with mental health disorders have the opportunity for socialization, empowerment and advocacy; and individuals with mental health disorders direct and operate the services, building the skills and self-confidence which increase the potential for future employment opportunities. There is only one Peer run drop-in center in Mississippi. The Opal Smith Consumer Center is supported with DMH funding as well as a SAMHSA grant awarded to the Mental Health Association of South Mississippi. The center employs 3 Peer specialists who oversee the Advisory Council made up of 100% consumers, assist in the organization and planning of center activities and programs, lead sessions such as Wellness Recovery Action Plan development and provide individualized Peer support. The lack of stringent requirements and structures allow attendees to benefit from the socialization and support provided by the center while maintaining jobs, going to school or just participating for the part of the day that they can tolerate.

In addition to "stigma-busting," the center is initiating a Leadership Academy designed to prepare consumers for roles as future leaders in the mental health system in Mississippi. The center has reached its capacity however (the space funded can only accommodate a finite number of people) and cannot serve the number of individuals who want to participate, resulting in a waiting list.

Supported Employment

According to a recent study by the University of Minnesota, in Mississippi, 49.3% of adults with a disability live in poverty.[21] Disability can be a significant factor in an individual's ability to earn a living wage and to meet their basic needs. For most adults employment provides the primary means to achieve economic independence and self-sufficiency, and provides a source of identify and self-esteem. Yet individuals with disabilities are often challenged to access the labor market due to a variety of social, cultural, and economic barriers. Even those who do find employment may work in facilities that pay below the minimum wage. Therefore despite being employed they cannot achieve economic independence.

Supported employment is another evidence-based approach recognized by SAMHSA.[22] Employment specialists help people find jobs in the open labor market that pay at least minimum wage and that anyone could have, regardless of their disability status. Employment specialists help people look for jobs soon after they enter the program, eliminating the need for sheltered employment or vocational

[19] www.latimes.com/.../la-oe-morrison-burns-20140723
[20] http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/TheEvidence-COSP.pdf
[21] http://rtc.umn.edu/prb/251/
[22] http://store.samhsa.gov/shin/content//SMA08-4365/TheEvidence-SE.pdf

readiness. Once a job is found, employment specialists provide ongoing support, as needed. Choices about work are based on a person's preferences, strengths, and experiences.

Unlike sheltered workshops, supported employment integrates individuals with disabilities into their communities and leads to greater independence. Mississippi is on target by no longer funding sheltered workshops for individuals with serious mental illness. In January, DMH provided funding to develop four pilot sites that will offer Supported Employment to a total of 75 individuals with mental illness. The sites will be located in Community Mental Health Center Regions 2, 7, 10 and 12 and are expected to deliver services with fidelity. DMH is to be commended for identifying funding for the pilots with the goal of submitting a 1915i state plan amendment for expansion of supported employment initiatives statewide.

Housing

A good and modern mental health system must include emphasis on safe, affordable and integrated living environments. The likelihood for individuals to focus on and maintain their recovery absent residential stability is poor. Yet, there is lack of emphasis in Mississippi on housing related services designed to help individuals secure and maintain housing and gain the skills necessary to live in integrated settings. Nor has there been an emphasis on developing integrated, affordable housing opportunities for individuals with mental illness. It is important to note that the burden of affordable housing development should not fall upon the disability service system, and the State's approach to affordable housing should include individuals with mental illness and other disabilities.

Table 6 below summarizes the residential services supported by the 14 CMHCs.

Table 7: CMHC Funded Adult Residential Services

	MH Group Home	MH Supervised Living	MH Supported Living	A&D Primary Residential	A&D Transitional
# of CMHCs Providing Service	6	5	5	11	9
# of CMHC Beds	135	73	198	354	209

Analysis of the residential data indicates that in spite of DMH's efforts to promote Supervised and Supported Living, 6 CMHCs continue to support "group homes," a model that is unnecessarily restrictive and segregates adults with serious mental illness from full integration in their communities. DMH reports that the group homes were funded with grants allocated many years ago and that they have little ability to impact how the CMHCs use the funding. The CMHC data indicates that the lengths of stay in the group homes average "many years."

The Supervised and Supported Living programs that do exist tend to be provided in congregate living settings and in apartment buildings or complexes where more than 20% of the residents are persons with disabilities. Occupancy rates for all mental health residential options run consistently at 90% or above with several CMHCs reporting 100% occupancy. As shown above in Table 2, less than half of the CMHCs offer community living programs for individuals with SMI. More CMHCs provide residential services for individuals with alcohol and drugs (A&D) abuse disorders; 11 CMHCs provide A&D Primary

Residential beds and 9 provide A&D Transitional Living beds. Occupancy rates in A&D residences are much lower, however, averaging 69.9% in Primary and 61.4% in Transitional programs.

DMH also operates the Central Mississippi Residential Center (CMRC) in Newton. DMH has operated the CMRC since 1996 to provide extended housing and treatment for individuals discharged from long-term treatment received in a Mississippi state hospital. Since the residents are discharged from the state hospital the CMRC has been viewed as a tool to reduce state hospital bed capacity. Currently the campus provides 4 twelve-bed Supervised Living residences with 24-hour staff supervision and 12 two-bedroom Supported Living apartments where staff monitors individuals as needed. The CMRC is the only formalized residential support for residents of the Weems Region; its Board declined the offer from DMH to take over the campus and has not developed alternative residential options as the Board does not view mental health residential services as aligning with its mission. Individuals from the Weems Region comprise 50% of persons served at the CMRC while individuals referred from other state hospitals and CSUs comprise the remaining 50%.

Of adults discharged from Mississippi state hospitals in 2014, 74.5% returned home, 5.2% went to a group home and 8.5% went to live in a board and care home. While that 74.5% return home rate is notable, it has not meant stable or quality living options for all of these individuals. Given the lack of sufficient community living options, adults with mental illness and addictive disease often live in less than optimal situations. Stakeholders provided examples of individuals living with aging parents; some living with family and "friends" who reportedly rely on their SSI income to support the household; and others living in board and care homes, many of which are not licensed and reportedly take the residents' SSI checks and leave little if anything for the individuals' personal spending.

Even more tragic is the number of homeless individuals with disabilities, including serious mental illness and addictive disease, in Mississippi. According to current Mississippi Homeless Management Information System (HMIS) data, as published in the 2013 Annual Homeless Assessment Report (AHAR) to Congress, Mississippi's data has a total of 2,403 homeless individuals. Of that total, 1,320 or 54.9% were unsheltered, the 5th highest rate of unsheltered homeless people in the country. When the 2013 Homeless Point in Time Survey was conducted on a single night in January, Mississippi had more than 80% of chronically homeless people who were unsheltered. Of the total number of homeless individuals, 475 (20%) were chronically homeless and 498 (21%) were identified as having a substance use disorder.[23] DMH took the initiative to apply for, and was awarded, a Cooperative Agreement to Benefit Homeless Individuals grant from SAMHSA to help address this crisis. The purpose of the initiative is to address the housing and support service needs of 297 persons who are experiencing chronic homelessness with substance use or co-occurring substance use and mental health disorders.

[23] Mississippi Department of Mental Health, MS Housing 4 Recovery (MH4R) Initiative proposal

The lack of safe and affordable housing in Mississippi was captured in detail in TAC's October 2014 report *A Statewide Approach for Integrated, Supportive Housing in Mississippi*[24] and TAC has provided technical assistance throughout this process to DMH and the Attorney General's Office to move forward legislation supporting the creation of a Special Needs Housing Council and the funding for bridge rental subsidies. In addition, DMH has committed CABHI resources to help reduce the reliance on inpatient, including state hospital, beds. However, the need for PSH is far greater than the number of units that can be supported with the proposed resources.

Recommendations

TAC proposes that the community-based service array for adults with serious mental illness and/or addictive disease in Mississippi should be enhanced in order to better support a life in the community.

PACT/Mobile Treatment

In addition to assuring fidelity, DMH should support and require all PACT Teams to receive training and technical assistance on Recovery, community integration and housing supports, and how that translates into services that add to recipients' quality of life. Teams have focused on reducing hospitalizations, CSU admissions and incarcerations with positive results. Teams have provided less focus on developing natural supports and use of community alternatives to traditional CMHC programs. The PACT team members clearly care about the individuals they support, but they describe their relationship with consumers as caregivers and caretakers, some in fact referred to themselves as the consumer's "family." PACT is intended to help service recipients use and develop natural supports, not replace them.

DMH must require the legacy teams to begin billing Medicaid for eligible recipients/services. As part of this process, DMH and DOM staff should meet with the Teams to understand their concerns with paperwork and prior authorization and streamline administrative requirements to maximize time spent in service delivery. Spending 100% state funding on a service which is Medicaid eligible and thereby reduces the state's funding by about 70% for MA eligibles is not a sound financing strategy.

DMH and DOM should work together to estimate the number of individuals who could be eligible for PACT and plan accordingly. Estimates have ranged from .06% to .1% of the total adult population to upwards of 20% to 40% of the adult SMI population.[25] State funds could be used to start-up new teams and then re-allocated as teams begin to generate Medicaid revenue for eligible services. In addition to expanding and shoring up PACT services, DMH and DOM should assess the potential for implementation of an alternative to PACT for individuals who may not meet the stringent eligibility criteria but who would benefit from mobile treatment and support. In-home therapy with medication management and Peer Support has proven to be successful as well as Medicaid reimbursable in other states.

[24] http://www.dmh.ms.gov/wp-content/uploads/2014/10/A-Statewide-Approach-for-Integrated-Supportive-Housing-in-Mississippi3.pdf

[25] Cuddeback, Gary, Morrissey, Joseph, and Meyer, Piper. *How many assertive community treatment teams do we need?* Psychiatric Services, December 2006. Vol. 57, No. 12.

Psychosocial Rehabilitation/Day Support

Defining these services separately may be advantageous for billing, but absent a vision and framing of the services to meet that vision, providers appear to be focused on delivering services that generate the highest revenue. DMH should issue policy for the delivery of comprehensive PSR and Day Support services for skills development and attainment, including the expectation for billable off-site services to encourage practicing and monitoring of skills attainment. The need for skill development, practice, measures and timelines for attainment should be included in individualized service plans based on the needs and choices of service recipients and should not be driven by the Medicaid rate. DMH monitoring should include an assessment of the delivery of person-centered PSR and Day Support services as indicated by a reviewed sample of service plans.

Expand Peer Run Drop-In Centers

DMH should identify, or request additional funding, for Peer run drop-in centers that follow the evidence-based practice as outlined in SAMHSA's toolkit. In addition, DMH must articulate and model a vision for Recovery that includes consumer empowerment and leadership. Peer support should also be required across the continuum of services, including inpatient, emergency rooms, mobile and other crisis-oriented services, warm lines, PSH, PACT and other traditional services.

Implement and Further Develop Supported Employment

DMH should implement a strong evaluation component with the 4 newly awarded grants for Supported Employment. The evaluation should assess both the process followed, as well as the outcomes for individuals, as outlined in SAMHSA's toolkit for evaluating supported employment services.[26] Lessons learned and results of the projects should serve to inform the use of Medicaid reimbursement, such as for a 1915i State Plan Amendment.

DMH should identify or request additional funding to provide additional grants for start-up costs to further expand Supported Employment initiatives, building on the successes and lessons learned from the pilot projects.

Adults with serious mental illness and addictive disease should also have access to job training and supports that are available to other adults with disabilities in Mississippi. DMH should work with the Mississippi Department of Rehabilitation Services to establish benchmarks for job training and employment services for adults with serious mental illness and/or addictive disease.

Housing

Implement and Expand Permanent Supportive Housing

Per the agreement outlined in the August 29, 2014 letter, Mississippi should implement the project-based rental assistance program for 50 individuals in FY 2015 with serious mental illness being discharged from state hospitals or who have histories of state hospital or frequent admissions to CSUs; and a minimum of an additional 150 adults in FY 2016.

[26] https://store.samhsa.gov/shin/content/SMA08-4365/EvaluatingYourProgram-SE.pdf

TAC recommends that DMH establish eligibility criteria for PSH as outlined in the October 2014 Housing report and develop a methodology to determine the need for PSH in Mississippi. This will inform the budget decision making process regarding the number of affordable housing units, state funded rental subsidies and services that are needed. An option is to use a methodology devised by TAC for other states to project the need for both affordable and permanent supportive housing (PSH) among persons with serious mental illness (SMI) and serious and persistent mental illness (SPMI) living within Mississippi.[27] People with disabilities including mental illness are overrepresented among those in poverty and have a need for affordable housing. To project this need, 2010 U.S. Census Bureau and Social Security Administration data would be examined to obtain basic demographic, poverty, and Supplemental Security Income (SSI) utilization information. Prevalence estimates from DMH's most recent SAMHSA Block Grant application would then applied to project the state's adult population with mental illness living in poverty and therefore the supply of affordable housing that should be available.

Since not all people in need of affordable housing would necessarily choose to live in or meet the definition of being in need of PSH, the number of individuals with mental illness who have the unmet, highest priority need for PSH would also be estimated. This estimate would include: a) the number of non-elderly people with mental illness receiving SSI disability payments, which is considered a reliable proxy of the need for both public sector human services and affordable housing; and b) the number of homeless individuals with mental illness identified through Mississippi's homeless Continuum of Care's (CoC) 2014 point-in-time (PIT) count who are likely not yet enrolled but qualify for SSI. This estimate would then be applied to the number of consumers currently served in supportive housing and other residential programs to reach a projected need for DMH housing.

Based on this assessment and with the input, review and approval of the Permanent Supportive Housing Committee, DMH should develop a 5-year plan for the ongoing expansion of PSH in Mississippi. Expansion should be targeted to regions where the public housing agencies are willing to target housing vouchers for adults with serious mental illness and/or addictive disease. Treatment and support services must also be assessed to assure a comprehensive array of services and supports are readily accessible.

Transform/Align Current Housing

DMH should work with the CMHCs to continue transforming all remaining MH group homes. All residents in group homes should be assessed to move into PSH. Some vacancies in group homes created as a result of these transitions, could serve individuals with complex needs in the community, avoiding unnecessary admissions to, or days spent in, state hospitals, such as those with co-occurring mental illness and complex medical needs. However, as individuals move into PSH, not all existing group home beds will need to be backfilled, resulting in an opportunity to re-allocate group home funds to more integrated housing and services. The funding made available as a result of the transformation should be used to expand or enhance support services for individuals living in permanent supportive housing.

[27] District of Columbia, Department of Behavioral Health. Supportive Housing Strategic Plan, 2012 – 2017. September 2012.

DMH should work with CMHCs to bring all HUD funded congregate living programs into compliance with *Olmstead,* as well as recently published guidance for home and community based services by CMS[28], by no later than 2020.

Policies

DMH should issue a policy prohibiting any state hospital from discharging a patient to a shelter or un-licensed board and care home and provide community education about the policy.

DMH should require CMHCs to provide regular and ongoing assessment of the housing stability of persons served. Individuals who are in less than optimal housing should be informed of other housing alternatives.

Expanding Provider Capacity and Enhancing Existing Services

Assessing the adequacy of services

Ready access to individualized services and supports has proven key for successful PSH initiatives throughout the country. Recovery from mental health and substance use disorders is not linear; individuals are likely to need more and less support at times, and the level of need can change quickly. Services need to be flexible and responsive to increase: 1) the likelihood for individuals to remain stable in their housing; and 2) the willingness of housing providers to continue offering units to individuals with mental health disorders.

Mental health and housing stakeholder interviewees expressed concerns about the lack of readily accessible and responsive services to support individuals in PSH, particularly individuals with challenging behaviors. Yet little data was available to confirm these observations. According to Mental Health America's 2015 report (based on 2012 data),[29] the assessment of service adequacy found that:

- Mississippi ranks 50th in the nation for access to Mental Health Care; and
- Only 34.9% of adults with any mental illness in Mississippi receive treatment

DMH confirmed that access continues to be a concern in its own 2014 Annual Report, estimating that 165,000 Mississippians were in need of mental health treatment[30] but only 57,797 adults were served. Not only were less people served than in need, but the number represents a decrease from 69,474 adults served in 2012.

[28] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html
[29] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America.

[30] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf

TAC had access to data and indicators such as the number of licensed mental health and alcohol and drug service providers or certified practitioners, and the units of service financed by Medicaid, however it's unclear if these measures reflect past *practice*, or the actual *capacity* for the system to serve and support individuals. In addition, the number of licensed programs or practitioners doesn't indicate the degree to which those programs offer, or staff are trained in delivering, evidence-based or promising practices. Stakeholder interviews and site visits offered key insights to round out the assessment of service capacity.

Accessibility and adequate capacity is especially relevant for key Core services such as outpatient and psychiatric treatment, crisis intervention services and Peer Support services.

Outpatient Therapy/Psychiatric Services

CMHCs are legislatively mandated, but operate under the authority of a local board of commissioners and not the Department of Mental Health. As previously stated, CMHCs are required to offer core services for all residents within their regions; however, the degree to which services are available varies considerably. In Region 8, a full continuum of readily accessible services is available at a CMHC in every county served by the Region. Intake appointments and psychiatric appointments can be accessed within 24 hours of contact if the need is identified as a "crisis." Likewise, appointments can be accessed within a day at Region 15. At the opposite end of the spectrum, residents of counties within the Gulf Coast Region may wait as long as 4-6 weeks for an intake appointment and 6-8 weeks for a psychiatric appointment. Over half of the CMHCs identified at least a three week wait, and often longer, for a psychiatric appointment. Please see Appendix XX for all CMHC survey responses. The lack of readily accessible treatment, including medications, compromises the ability for individuals with serious mental illness to maintain successful lives in their communities.

Access to medications is a challenge for individuals ineligible for Medicaid or private insurance. CMHCs report using Pharmaceutical Assistance programs, samples, grants and some are able to provide a small amount of funding to support limited access to medications. However, the inability to fully access needed medications is a contributing factor to hospital readmissions and involvement with crisis services. Medicaid pays for psychotropic medications included in its formulary but has recently changed its procedures for certain agents. CMHCs are now required to purchase injectible medications and store them for administration when the recipients come to the Center for their injection. This practice, referred to as "buy and bill," incurs up-front costs for the CMHCs which they must then recoup by billing for administration of the medication to each recipient.

Formularies also present challenges for individuals in accessing medications. Neither the state hospital or DOM staff who were asked could say if the medications prescribed to individuals being discharged from the state hospitals were on Medicaid's or the CCOs' formularies. The state hospital physician may prescribe the most effective medication for a patient upon discharge, but the individual may not have ongoing access to the medication. State hospital physicians prescribing practices and the availability of medications in the community must be aligned for persons being discharged to facilitate successful transition.

Crisis Intervention Services

Emergency/Crisis Services are identified by DMH as Core services. It appears, however, that not all components of Crisis Services are available and readily accessible statewide.

Expanding Crisis Stabilization Units

Mississippi relies on nine (9) Crisis Stabilization Units (CSUs) to divert admissions from acute psychiatric and state hospitals. Once operated by DMH, all but one CSU is now operated by a Community Mental Health Center (CMHC). CSUs provide 24-hour treatment and supervision in facilities with no more than 16 beds.[31] While CSUs are able to admit individuals under involuntary commitment, they do not typically provide the level of security or safety features required for individuals with highly threatening or violent behaviors[32]. In addition, CSUs are not hospitals nor are they located on hospital grounds, and are not able to admit individuals with significant health care needs.

The number of admissions and longer average length of stay compared with typical acute inpatient stays of approximately 7 days suggests that individuals fall to the acute part of the system absent more robust community services. In FY 2014, CSUs admitted 4,251 adults; 33.6% were referred from Chancery Courts and 25.4% were self-referred or referred by family. The average length of stay was 9.58 days. Medicaid funded treatment for 35.8% of all admissions, Medicare and private insurance covered about 8%, and DMH grant funds supported treatment for 55.4% of admissions who had no health care coverage or ability to pay for their services. One-third of admissions had previously been admitted to a CSU, though data is not available on the timeframe or number of the prior admissions. Discharge data indicates that only 12.5% of admissions were referred for further treatment at a state hospital.

In addition, not all individuals who would have been appropriate for admission to a CSU were referred. Chancery Courts have the authority to commit individuals directly to a state hospital for treatment. While DMH does not capture data on these occurrences, staff reports that some Courts continue this practice in spite of their efforts to educate the judges on the purpose and benefits of CSUs.

CSUs were effective at keeping most people served out of the state hospital, but not all referrals to the CSUs were admitted; 1,174 referrals could not be served due to:

- No beds at the time of referral – 21.6%
- Severity of medical issues - 16%
- Behavior too violent – 13.3%

While all CSUs are required to adhere to the same DMH standards, there is variability across the CSUs. For example, CSUs reported referrals from a variety sources with the exception of Corinth, which reported referrals only from Chancery Courts and Self/family. Tupelo reported serving 38% of all Medicare eligibles served by CSUs. Brookhaven reported being unable to admit the highest number of

[31] Gulf Coast CSU is the exception.
[32] Gulf Coast CSU has the ability to admit individuals whose behaviors may cause harm or injury to others

referrals due to the lack of a bed at the time of referral, while Grenada reported the most frequent inability to admit individuals due to Medical complexity and violent behaviors Table 3 below indicates the range of variability across the CSUs for selected data elements. Please refer to Appendix X for a summary of all data elements reported by the CSUs.

Table 8: Select Data Elements Reported by CSUs

CSU Facility	Admissions	Involuntarily Committed	Chancery Court Referral	Law Enforcement Referral	CMHC Referral	Days in Jail Pre-Admission	Previous CSU Admission	Discharge to DMH Hospital
Lowest	345 Cleveland	16% Newton	.2% Gulfport[33]	0 Batesville, Corinth, Grenada	0 Corinth	0 Brookhaven	21% Corinth	0 Laurel
Highest	668 Newton	81% Tupelo	81% Tupelo	25% Newton	42% Brookhaven	602 Gulfport	54% Gulfport	25% Gulfport

Five of the fourteen regions do not have a CSU and residents must travel to another region for the service. When any CSU is at capacity, subsequent referrals are re-directed to the closest CSU with an empty bed or to a state hospital. Since CSUs serve as the primary diversion from state hospitals communities without ready access to this resource are more likely to look to the state hospital for admission. DMH staff expressed no interest in investing resources into building additional CSU facilities but would prefer instead to locate/co-locate beds in existing facilities or structures.

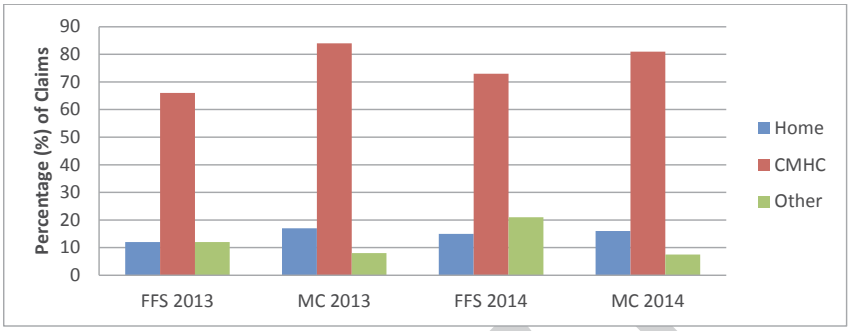
Enhancing Mobile Crisis Emergency Response Teams

The rural nature of Mississippi and pervasive poverty are contributing factors to the lack of ready access to treatment. Formalized transportation does not exist outside of the major metropolitan areas and many living in the poorest regions do not have personal transportation. In 2012 DMH issued grant funds to the regions to develop Mobile Crisis Emergency Response Teams (MCERT), intended to respond to a person experiencing a behavioral health crisis at the location where the crisis is occurring, in order to provide assessment, stabilization and alleviation of the crisis situation.

All of the CMHCs received DMH grant funding to implement MCERT. Teams are typically “dispatched” based on an assessment of need by a supervisor at the CMHC or an on-call Crisis Supervisor after-hours. While the teams are intended to go to the location of the crisis, Medicaid claims data indicates that most mobile crisis services were delivered at the CMHC offices.

Figure 3: Medicaid Claims for Adult MCERT by Place of Service

[33] In Gulfport, CSU staff are “deputized” to involuntarily commit



MCERT members interviewed identified "safety Issues" as preventing teams from going into the homes of individuals new to their agency. While law enforcement can be accessed at times to accompany a team on a call, this support can be especially difficult to obtain in the more rural counties. According to DMH data, of the 4,344 face-to-face contacts in FY 2014, only 549 involved accompaniment by law enforcement[34]. In order to address safety concerns Crisis team members reported that they attempt to identify a "neutral" location to meet the individual or family member but it appears that the majority of contacts occur at the CMHC offices. Several states have addressed these concerns through enhanced training and dispatching two staff when necessary.

Another challenge for MCERT is educating "the system" and individuals in crisis about the availability of the service. CMHCS were allowed to spend up to 10% of their grant funding on educating the community about the service; several shared various strategies including posters and pamphlets showcasing the service and toll free contact numbers, attending health fairs and public events, running public service announcements, and placing ads in local publications. Yet, numerous family stakeholders, advocates, and non-CMHC behavioral health providers that we interviewed stated that they were not aware of the mobile crisis service. If individuals who could benefit from mobile crisis are not aware of the service, people in crisis and their family members are likely to resort to past practice for seeking help.

There are several examples of rural states and communities that operate mobile crisis response teams including the Appalachian Community Services Crisis Management program in North Carolina[35], The Eastern Shore Mobile Crisis Teams in Maryland[36], the Washington County Mobile Crisis Service in Vermont[37] and the Mobile Crisis Response Teams operating throughout Tennessee[38]. These teams have common characteristics:

- Centralized 24-hour telephone access for screening/triage;

[34] 2014 DMH Report of Mobile Crisis Emergency Response Team Data
[35] http://www.ncbi.nlm.nih.gov/pubmed/22779153
[36] http://mdruralhealth.org/2014conf/ESMC.pdf
[37]https://www.wcmhs.org/crisis-access.html
[38] http://tn.gov/mental/recovery/crisis_serv.shtml

- Capacity for face-to-face intervention with trained crisis professionals in a safe and secure location within 1 hour of contact;
- Access to a continuum of services and interventions aimed at stabilizing the crisis without inpatient admission, as well as access to inpatient when needed; and
- Access to referral for follow-up care, typically within 24 hours.

The teams report investing considerable time and effort in establishing community relationships and linkages, which serve to identify potential/emerging crisis situations and to provide safe places for crisis assessment and interventions to occur. Their communities have also invested in Crisis Intervention Teams that work hand in hand with the Mobile Crisis Response Teams.

DMH staff acknowledges that MCERT is a work in progress and that introducing mobility for crisis services in Mississippi has been a major undertaking. DMH reports investing considerable time and resources into sponsoring training for the teams to build skills in crisis de-escalation and stabilization as opposed to assessing for commitment, and at providing services at locations outside of the CMHCs.

Enhancing Crisis Telephone and Walk-in Services

During business hours these functions appear to be carried out by an available therapist or clinical services manager at the CMHC. Stakeholder interviews depict these services as predominantly assessment for inpatient civil commitment whereas their purpose should emphasize crisis stabilization or inpatient diversion. Expanding the telephone service to include Peer and Family Mentor operated "warm lines" has been an effective strategy utilized in other states to provide support to individuals before they reach a psychiatric crisis. Peer and family mentors can offer a listening ear, empathy and support for an individual or family member who is struggling, as well as share successful tools and resources for managing a crisis and avoiding an inpatient admission. Peers and Family mentors are also effective in sharing coping strategies and offering support in crisis walk-in settings.

Expanding Peer Support Services

Peer Support is one of the more recent EBPs implemented by DMH. While DMH has supported the training and certification of Peer specialists, the Division of Medicaid is the primary funding source for the service. Identified as a Core service, the disparities among CMHCs is clearly evident with accessibility to Peer Support. In FY 2014 the number of Peer Support positions ranged from a low of 1 in two regions (with one region having a vacancy) to a high of 12 in one region with all positions filled. The number of individuals receiving Peer Support ranged from 3 in one region to 350 in another. A challenge CMHCs identified in delivering the service was the ability to keep positions filled with full-time employees. Several CMHCs have created part-time positions to minimize the stress of full-time employment on the Peers which appears to be a successful solution. In addition, Mississippi has a Peer Support Coalition to provide networking opportunities and support for the Peers.

One explanation for the lack of service provision is likely to be the low rate of reimbursement. At a rate of $ 7.83 a quarter hour of service, CMHCs are not incentivized to expand peer service delivery. Other contributing factors include the stigma associated with mental illness and very little buy-in to the idea that people can and do recover from serious mental illness and/or addictive disease.

DMH recognizes that a sub-population of the individuals in the system have had repeated CSU and state hospital admissions, do not respond to traditional community-based services and have not responded with interest in PACT team support. Peer Support Specialists have proven to be effective in establishing relationships with individuals with serious mental illness and with addictive disease who lack trust in professional staff. DMH is considering the targeted expansion of Peer Support Services in an effort to engage this hard to reach population. As stated earlier, peer delivered services should have a place at multiple intercepts throughout the system.

In addition, DMH could do more to support the development of an informal network of peer supports. Strong peer support coalitions in several states provide an additional level of peer support, and also empower consumer influence at the policy and provider level.

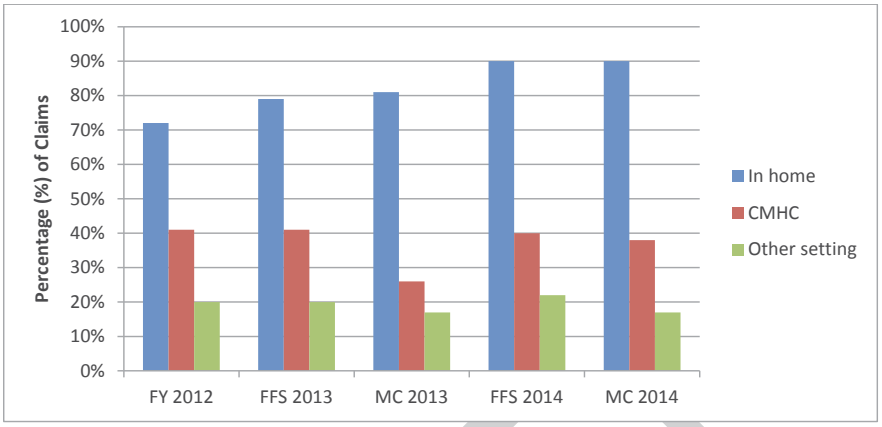
Enhancing Targeted Case Management/Community Support Services

Community support services (CSS) were established in 2012 in Mississippi as an alternative to Targeted Case Management (TCM). Mississippi included CSS as a Medicaid covered service under the Rehab Option to define hands-on direct service provision apart from the clinical and administrative targeted case management functions.

As currently defined, TCM is intended to provide the independent development and monitoring of an individual's treatment plan, to ensure that treatment team members complete tasks that are assigned to them, that follow up and follow through occur and to help identify when the treatment team may need to review the treatment plan for updates if the established plan is not working. TCM must be delivered by a Licensed Social Worker or a Registered Nurse. CSS is intended to support individuals in their communities, outside of the office-based setting, to make sure that individuals are receiving the services and supports identified in their service plan, and to assist with skill building and service navigation. CSS can be delivered by a bachelor's level staff person.

Based on Medicaid claims data CSS appears to be delivered out of the office as intended; twice as many adults received services in their home than at the CMHC and twice as many units of service were provided in-home as opposed to the CMHC. In addition, services were billed for the location "other" which is not a CMHC.

Figure 4: Medicaid Claims for CSS by Place of Service



Medicaid data also indicates that more adults are receiving CSS than TCM; FY 2014 FFS and MC data reflect CSS billing for about twice as many adults as for TCM . This data appears to conflict with the State's intended relationship between the two services – that 'TCM manages the plan and CSS manages the person.' When asked why so many more recipients received CSS than TCM services, DMH explained that 'clients and families have the right to refuse TCM or not add it to their treatment plan.' When an individual doesn't have an independent TCM, the "primary service" provider typically manages the service plan/services, i.e. the individual and their therapist, community support specialist, or the clinician providing day services or therapy services. This practice may be a practical solution but it doesn't align with the objective of TCM…to have an unbiased party monitoring a recipient's care. Other explanations provided for the lower numbers of TCM recipients included the Medicaid payment limits on TCM, which can end Medicaid billing for the service while individuals continue to receive other services, and the credentialing requirements make it difficult for CMHCs to attract sufficient TCM staff.

An inherent limitation of both TCM and CSS services is the inability to bill for either service while a recipient is in the state hospital. The predominant funding source for both TCM and CSS is Medicaid and the current payment rules do not allow for billing until the individual is discharged from the state hospital back into the community. Effective discharge planning needs to begin at the time of admission, especially when the average length of stay in state hospital acute care beds is around 30 days. The lack of a guided transition or "warm hand-off" from the state hospital often results in individuals leaving the hospital and falling through the cracks. As discussed in the previous section on PACT, individuals with chronic conditions and little resources aren't able to make the transition on their own; this often results in inadequate aftercare, decompensation and readmission to a CSU or state hospital setting.

The lack of an alternative funding source for CSS during this crucial time of transition limits an important potential benefit of the service. DMH has recently responded to this dilemma by allowing CMHCs to re-direct 10% of MCERT funding previously identified for service promotion to funding for Making a Plan (MAP) Teams for adults. Based on this successful approach for children, MAP teams' responsibilities for adults include facilitating the provision and coordination of services and continuity of care for individuals

with repeated use of high-end services. Allowing more flexible use of funding is a positive step for DMH to take, however diverting funding from MCERT does not appear to be the ideal solution given that MCERT services are in need of further development.

Recommendations

The following are recommended strategies to enhance the availability and effectiveness of Core services.

Outpatient Therapy/Psychiatric Services

DMH should establish and enforce access standards for routine and urgent appointments for intakes and psychiatric evaluations, for all payer sources. Waiting for weeks, and in some cases months, for an appointment disrupts the engagement of individuals with newly emerging disorders,the smooth transition from CSU or inpatient care, and for those who may be experiencing psychiatric crisis. Managed care industry standards are an option to consider.

DMH must work with DOM, providers and universities to increase access to community-based psychiatric capacity. Options to explore include:

- Supporting and enforcing the use of telepsychiatry in every region. TAC understands that Tele-behavioral health is available currently in Mississippi via the Medicaid rehab option state plan amendment and that DOM is implementing new policies and procedures to provide Tele-behavioral health services across the state. DMH should use its certification process to insure that CMHCs take advantage of this opportunity to meet access standards.
- Allocating a portion of each DMH psychiatrist's time to provide on-site work at a CMHC and/or to provide consultation for primary care providers. Sharing resources would not only illustrate DMH's commitment to providing community-based services, it would increase continuity of care for individuals who are served by the same psychiatrist in both the state hospital and in the community, and help to address workforce shortage issues.
- Developing a community psychiatry residency rotation where psychiatric residents are rotated through the CMHCs. The residency rotation would provide additional psychiatric support to the CMHCs and expose residents to the rewards of working with individuals with serious mental illness and additive disease. In addition, residents may be more likely to stay and practice in Mississippi if the state were to fund and implement the loan forgiveness program approved by the legislature.
- Establish an expectation for each CMHC to set aside a minimum amount of funding annually to provide medication assistance to adults when *no other resources* are available. Given some CMHCs already do this, it can be done.

Crisis Services

Mississippi must improve access to community-based services as a way to reduce the need for crisis-oriented services such as inpatient, emergency rooms and crisis stabilization units. Crisis services should approach service delivery with an emphasis on community preservation and inpatient diversion.

MCERT should be required to deliver mobile services in the community 24/7/365. Enforcing standards and implementing performance measures are tools which should be utilized to ensure the delivery of MCERT services geared toward de-escalating and stabilizing crisis situations in lieu of inpatient admission and in locations other than CMHCs. DMH should assess potential opportunities and the resources needed to develop a centralized 24-hour hotline for access to consistent screening and triage. In addition, each team should adopt the strategies that other states' mobile crisis teams have found to be successful: developing strong relationships with a variety of linkages in the community; use of Urgent Care Centers, Federally Qualified Health Centers and Rural Health Centers to conduct medical clearances when needed; access to Mobile Teams across county and regional lines if closer and more accessible for the person in crisis; and establish at least one Crisis Intervention Team in each Region.

Mississippi should strengthen its crisis residential/respite capacity. A facility such as a mental health group home could be converted into a crisis residential program by enhancing staff, utilizing a peer-run model, and making minor physical plant modifications. Several successful peer-run crisis residential/respite programs exist throughout the country.[39] Crisis residential/respite capacity could also be situated in small apartment settings with accessible staff and/or peer support. MCERT could function as a gatekeeper to these beds to ensure that the most appropriate individuals access this level of service. In addition, many individuals can benefit from crisis related supports in their own home. Services, whether through MCERT, PACT, or CSS, for example, should have the capacity to intensify support to individuals in their own home during crisis periods in order to help alleviate the crisis and preserve the housing placement.

While TAC Supports DMH in not wanting to *build* additional CSUs, there are alternative approaches to offering acute psychiatric stabilization, especially in regions where capacity is limited. A number of CSU beds, based on the need from analysis of commitment data, could share space in an existing setting within a region. Yet another approach would be to negotiate access to existing acute care psychiatric beds in the community for individuals with no health care coverage. These options are likely to require DMH funding.

In addition to expanding capacity, Mississippi would benefit from enhancing the capacity for existing CSUs to admit and safely treat individuals with non life-threatening medical needs/conditions, and enhancing the staffing and interventions for CSUs to accommodate individuals with challenging behaviors. In addition, DMH should attempt to address those Chancery court judges that continue to order adults directly to a state hospital bed, bypassing the CSU as a diversion. An option that has worked in another state is to identify an influential judge to champion the positive impact of CSUs with fellow judges who are reluctant to use the service.

Peer Support Services

DMH should work with consumers, families and providers to establish a minimum threshold for the employment of Peer Support Specialists throughout the service continuum due to their effectiveness

[39] National Empowerment Center website. Crisis Alternatives. http://power2u.org/crisis-alternatives.html

and to help alleviate the workforce shortage. Employing Peer Specialists allows licensed practitioners to focus on the delivery of clinical services, and promotes recovery for individuals with lived experience as well as the persons they serve. DMH should follow through with staff's observations that Peer Specialists could be effective with engaging adults who are unwilling to receive support from PACT teams. Peers are also known to be effective in assisting individuals in the transition from institutional to community-based settings such as "Peer Bridgers,"[40] and can also be successful in helping individuals with important housing supports such as preparing application, housing search and household set-up. Finally, DMH should work with DOM to assess the adequacy of the Medicaid rate to ensure the rate supports service delivery and to insure that service limitations do not prevent individuals from receiving the amount of service for as long as Peer Support is needed.

TCM/CSS

During on-site monitoring of TCM, DMH should review a sample of TCM and non-TCM cases to insure treatment/service plans are developed with the consumer and fully address the recipient's preferences and needs. DMH should work with DOM to identify the impact of TCM and CSS service limitations on the adequacy of services available for recipients, and either revise the limits or develop an exceptions process as warranted. The CSS Medicaid rate should also be assessed to determine if the rate presents a barrier to adequate service delivery.

DMH should provide funding for providers to deliver case management services to individuals with serious mental illness during hospitalization, incarceration, or admission to CSUs in order to ensure continuity of care and to facilitate effective transition back to integrated community-based settings. Individuals and their families are often not able to navigate these transitions themselves and would benefit from case management assistance and support. DMH is considering the allocation of funding for additional adult MAP teams which could serve to bridge this gap. This may serve as an interim solution but will not provide the continuity that the TCM and CSS workers would provide.

Finally, DMH should require all CSS staff to participate in annual training on recovery-oriented practices, expectations of DMH regarding business practices and clinical interventions that support community integration, integrated settings and person-centered planning. Providing services Monday through Friday during typical business hours, based on a professionally driven treatment/service plan does not meet the objective of the person-centered care necessary to support successful, integrated community living.

Is there ready access to services and are the services available consistent with a good and modern mental health system?

[40] National Empowerment Center website. Creating Replicable and Sustainable Peer Supprt Services. http://www.power2u.org/creating-replicable-sustainable-peer-support-services.html

As mentioned earlier in this report DMH requires that CMHCs offer certain "core services" to any one in need of the services who resides within the region. However, as evidenced by the variability in access to Peer Support and psychiatric appointments for example, designating a service as "core" does not necessarily mean adults will have ready access to the service, particularly for adults who are not Medicaid eligible. Access to most mental health and substance use services is dependent upon available funding, and for individuals enrolled in MississippiCan, approval of service authorization requests by the Coordinating Care Organizations. There is a wide gap between requiring services to be offered and people actually receiving those services in Mississippi.

There is also a gap between the Core services and the breadth of services needed to support adults in their recovery. In April 2013, DMH and the Strategic Planning and Best Practices Committee, established as part of the Rose Isabel Williams Mental Health Reform Act, conducted a survey of external stakeholders to identify needed or desired revisions to the Core services that CMHCs and other DMH approved and certified mental health service providers offer. While survey respondents indicated that the existing Core services should be maintained, they also recommended additional core services for adults including: employment related services; transportation; supportive housing options; expanded crisis services, including Crisis Intervention Teams and additional CSU beds; increased PACT teams; and supportive services such as money management, Peer Support, family education and respite.

While most of these services have not been added to the list of Core services, DMH has or is in the process of, implementing several of the recommendations. Four CMHCs responded to a recently released RFP from DMH for grants to provide Supported Employment Services. Grantees will receive technical assistance provided by NASMHPD and funds to initiate services with fidelity to the Dartmouth Approach beginning January 1, 2015. In response to the TAC report on PSH and compliance with the DOJ agreement letter of August 29, 2014 DMH is requesting funds to create 50 bridge rental subsidies with housing support services in FY 2015 and an additional 150 subsidies in 2016, targeted for individuals with serious mental illness with histories of state and community hospitalizations, arrest and incarceration and homelessness. DMH has provided training and continues to support the East Mississippi Crisis Intervention Team (CIT). Finally, four new PACT teams came on line and started building caseloads in December 2014 and DOM recently identified funding to start-up two more teams for a total of eight.

Are there limitations or barriers to expanding community-based provider capacity?

Lack of State investment in community-based services

DOJ's findings with respect to the lack of community-based services resulting in the over-utilization of state hospitals for adults are well documented in its December 22, 2011 letter to then Governor Barbour and will not be discussed in detail here. Since the findings letter was written, there have been changes to the array of behavioral health services and supports as a result of DMH initiatives as well as modifications to the Medicaid program. The development and expansion of PACT teams should decrease, and reduce, the over-reliance on inpatient treatment. The development of mobile crisis teams is conceptually on target, though greater benefits from the service should be realized when DMH holds the CMHCs to the MCERT standards. The development of permanent supportive housing units through federal initiatives such as the Balancing Incentive Program and CABHI, and newly requested funding from the Legislature

will create safe and affordable housing capacity. DMH has made progress in developing home and community based services and supports for adults with serious mental illness and/or addictive disease but there continues to be significant unmet need.

The Impact of Inadequate Funding

According to 2012 URS Tables, DMH served 107,277 adults and children. Of that number:

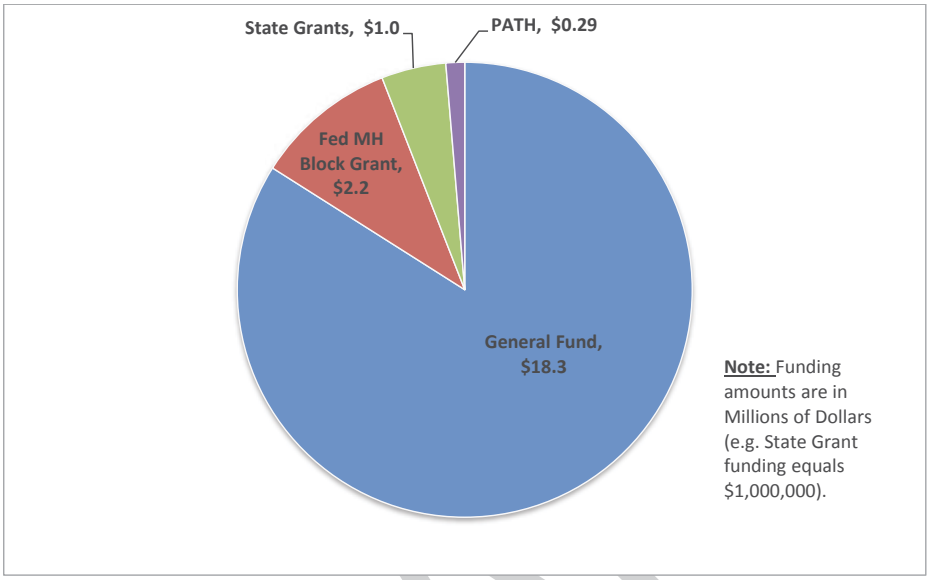
- 41,628 received no Medicaid funded service
- 11,360 received service but Medicaid status was not available
- 17,941 received both a Medicaid and non-Medicaid funded service
- 36,248 received only Medicaid funded service.

Of the total number served in 2012 about half received only DMH funded service and an additional 16.7% received both DMH and Medicaid funded service. Only about one-third of service recipients were solely Medicaid funded. In addition, of all adults served, only 13.2% were employed and *may* have had health insurance to cover any part of their treatment; Mississippi ranks 50th in the nation for the percent of adults with mental illness and no health insurance.

Based on this data it's likely that more than half of persons served in the behavioral health system in 2014 received only DMH funded or uncompensated care. The graph below depicts adult community mental health services funding in 2014.[41]

Figure 5: Adult Community Mental Health Services Funding

[41] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf



Funding for community services pales in comparison to funding for the state hospitals – $206.2 million in 2014. The bulk of DMH funding is used to support state-operated services, including the state hospitals and Central Mississippi Residential Center. Even when funds became available in 2014 for re-direction to the community, DMH elected to continue using the resources for state hospital operations. According to a June 2014 report released by the Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), regarding the closure of the Mississippi State Hospital's (MSH) Community Services Division, that by not, "….eliminating any of the division's positions and the plan to transfer its employees to MSH inpatient care positions, the department has forgone the opportunity to redirect resources yielded from closure of the division into providing community-based mental health care."[42] When asked about these plans, "officials of the Department of Mental Health (DMH), the department's and hospital's staffs perceived that the Community Services Division was outside the hospital's primary mission and believed that redirecting resources from community mental health services to acute inpatient care at the Mississippi State Hospital (MSH) was the best use of resources."[43]

The amount available for CMHCs to cover care for individuals not eligible for Medicaid is *very* small. So small that when asked, CMHCs indicated the funding was exhausted within the first few months of the fiscal year. In spite of DMH's requirement that the CMHCs serve everyone in need, businesses must have sufficient revenue to cover costs. The CMHCs reported they are struggling to serve the large number of individuals who lack Medicaid or insurance coverage. The lack of revenues limits their ability

[42] Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER). (June, 2014). A Review of the Closure of the Mississippi State Hospital's Community Services Division, Report #584. Retrieved on November 17, 2014 from: http://www.peer.state.ms.us/reports/rpt584.pdf
[43] Ibid.

to hire additional psychiatric coverage and licensed professional staff, impacting access to, and longer wait times for, services which can ultimately result in decompensation and admission to a CSU or state hospital bed.

CMHCs provided several examples of how the funding contributed by the state and the counties to cover community-based care for youth and adults with behavioral health challenges who lack health insurance does not adequately cover the costs of delivering these services. One CMHC served 1,240 adults and children without insurance in FY 2014 alone. Between FY 2010 and FY 2014, this Region saw a total funding decrease of over $3 million as a result of a combination of Medicaid managed care service denials and decreases in available federal block grant dollars. This funding decrease led to staff reductions. At the same time the number of service referrals increased, resulting in large caseloads for staff. Funding from DMH grants and county contributions only accounted for 4.4% and 1.1% of the Region's budget in 2014, respectively. Another CMHC reported providing behavioral health services to over 1,000 adults and children without insurance in FY 14, equating to almost $780,000 in indigent care. Yet another Region reported closing its crisis stabilization unit due to budget constraints and described experiencing significant losses, with auditors reportedly writing off approximately $8 million as a result of uncompensated and under-compensated care.

Table 8: Indigent Costs FY 2010 – FY 2014, as Reported by seven (7) CMHCs

Total Indigent Costs	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	CMHC 5 Year Total
Region A	$1,462,365	$1,039,834	$1,056,899	$818,274	$779,938	$5,157,310
Region B	$1,273,866	$1,268,382	$1,136,902	$1,134,321	$856,268	$5,669,739
Region C	$900,000	$1,800,000	$2,500,000	$2,699,221	$0	$7,899,221
Region D	$2,517,777	$2,660,346	$2,023,108	$2,059,193	$1,669,626	$10,930,050
Region E	n/a	n/a	$1,400,000	$1,400,000	$1,500,000	$4,300,000
Region F	$620,740	$720,329	$775,341	$460,292	$252,113	$2,828,814
Region G	$892,350	$779,283	$521,377	$630,166	$1,498,323	$4,321,499
Average Costs Each FY Year	$638,925	$689,015	$724,125	$707,805	$504,328	**Total from FY 10-14**
Total Costs Per FY Year	$7,667,098	$8,268,174	$9,413,627	$9,201,467	$6,556,268	**$41,106,633**

The lack of State funding has also inhibited further development of successful initiatives. **Crisis Intervention Teams** are an example. As a result of a growing number of individuals involved with mental illness interfacing with the criminal justice system, in 2012 Meridian and its surrounding communities came up with local funding to implement a Crisis Intervention Team (CIT). CIT provides specialized training for law enforcement officers to interact with individuals experiencing a mental health crisis. In addition to the training, the mental health system is prepared to respond promptly when an officer brings a person in mental health crisis to their attention, allowing the officer to return to his or her primary duties. CIT helps keep people with mental illnesses out of jail, and gets them into treatment instead.

In 2014, the Meridian Police Department and Lauderdale County Sheriff's Department responded to 189 crisis mental health calls through the East Mississippi Crisis Intervention Team (CIT). As a result of a coalition, including law enforcement, Weems Community Mental Health Center, Central Mississippi Residential Center, NAMI and other health care providers, only five of the calls responded to by law enforcement resulted in arrest (3%). The responding CIT officer was able to defuse the situation and/or make a referral for follow-up in 48% of the calls. 46% of the calls resulted in immediate transport and access to assessment and evaluation through the Crisis Stabilization Unit in Newton. As a result, approximately 177 individuals were diverted from the criminal justice system and provided immediate access to care. In spite of CIT's success most other communities have not followed suit, likely due to the lack of funding to cover the costs. CIT requires each officer to commit to 40 hours of training; most departments have to pay other officers overtime to cover the shifts of fellow officers while away from the job. With implementation of the Meridian CIT various community partners each contributed to the costs for start-up of the team. Most communities aren't willing or don't have the resources to do that. DMH could entice interest by issuing small grants to communities who could substantiate local buy-in to the approach.

Medicaid Cost Containment

CMHCs reported that Medicaid accounted for an average of 64% of total revenues in FY 2014.[44] CMHCs continue to struggle with the implementation of Medicaid managed care and fee-for-service (FFS) cost containment efforts.

Managed Care

Several CMHCs attributed significant revenue losses to discrepancies in eligibility and the frequent changes in CCO plan enrollment of individuals receiving their services. Reportedly, state level representatives for Medicaid, Cenpatico, and UHC all have acknowledged discrepancies in eligibility files. In Mississippi managed care enrollees may change health plans at any time. CMHCs reported it is not uncommon to receive denial of payment for services by the CCO from which they have a current authorization for treatment but the person served is no longer a member. Most CMHCs do not check recipient eligibility at every visit due to the increased costs that would be incurred from hiring additional administrative staff.

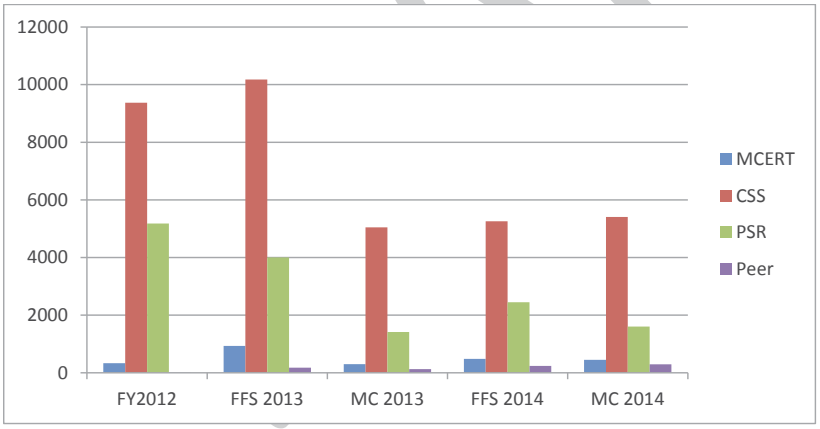
CMHCs reported that even when they do confirm a service recipient's eligibility, obtain a service authorization and provide the services, a recipient's eligibility can be changed and back dated. CMHCs reported examples of retroactive eligibility changes of several months. The CMHCs were then expected to return the "over-payment" to the CCO with the amount due deducted from a future payment, resulting in the CMHC providing uncompensated services. The CMHCs reportedly do not have any recourse or dispute resolution process.

[44] CMH Association data, absent Regions 8 and 11, 2014.

Mississippi is one of five states in the country operating a Medicaid managed care program (excluding Primary Care Case Management) that carves out inpatient behavioral health services from the managed benefit package[45]; inpatient services are covered under fee-for-service. A primary benefit of implementing managed care is to insure that the highest cost, most intrusive services are only provided to individuals who meet medical necessity criteria for the level of care or type of service, or when a less intensive alternative that could meet their need is not available. Managed care plans are typically afforded greater leeway in creating new and enhancing existing less intensive services in order to prevent covered recipients from needing to rely on the deep-end services such as hospital-based care. With inpatient excluded from the managed care contracts, there is no ability for CCOs to divert individuals from admissions to inpatient care, they are typically not informed when a member is admitted to inpatient care and they have no incentive to create alternative solutions. The only way for CCOs in Mississippi to realize savings is to reduce authorization and payment for community-based services.

The implementation of managed care has had mixed results for behavioral health services. Figures 6 through 11 below illustrate the impact of managed care implementation on several key community-based mental health services, from pre-managed care implementation in Fiscal Year 2012 to full implementation for covered populations in FY 2014.

Figure 6: Number of Medicaid Users of Select Community Based Services



[45] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html

Figure 7: Average Claims Per User of Select Community Based Services

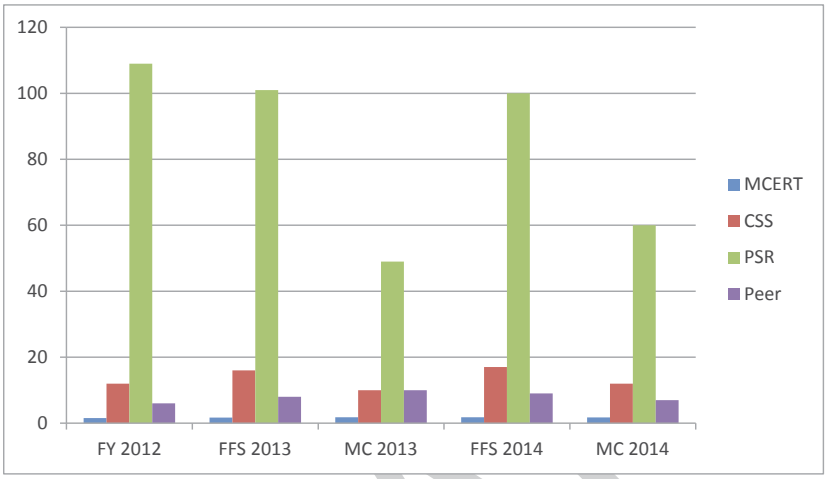
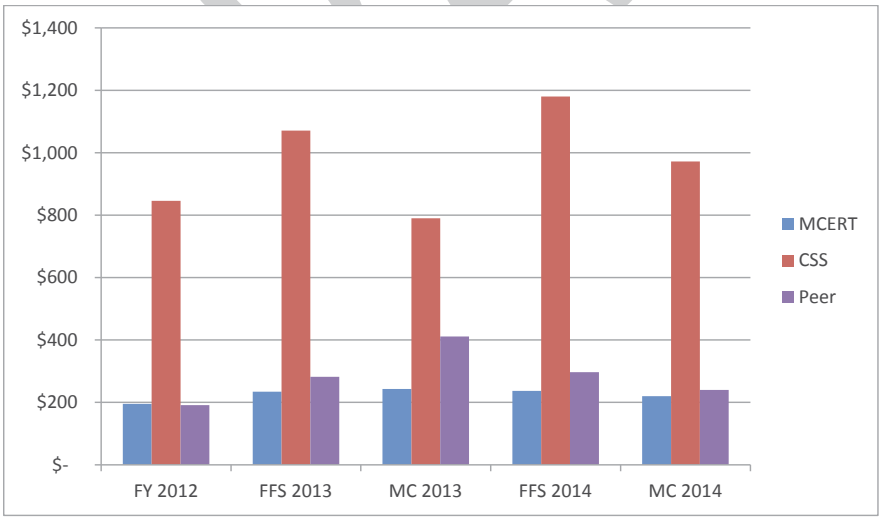


Figure 8: Average Paid Claim Per User of Select Community Based Services[46]



[46] CCOs are required to pay the same rates for services as Medicaid fee-for-service

Figure 9: PSR Average Amount Paid Per User

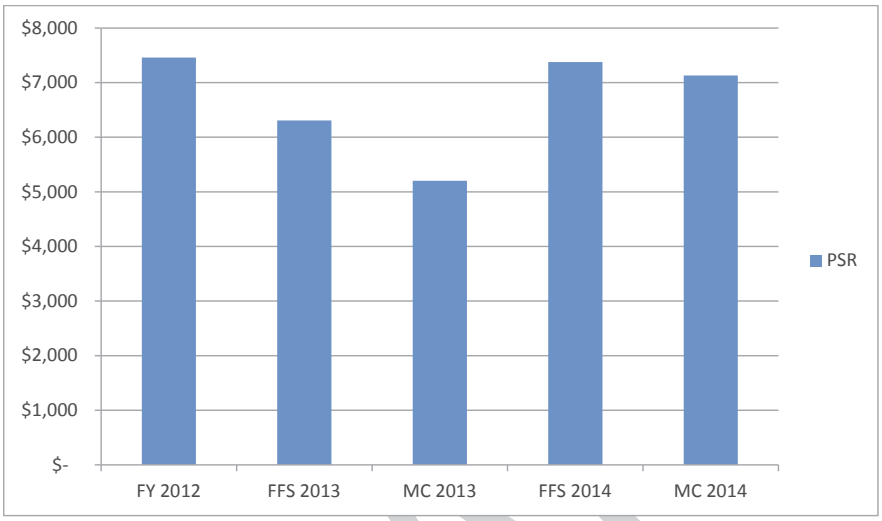


Figure 10: Total Medicaid Expenditures for PSR and CSS

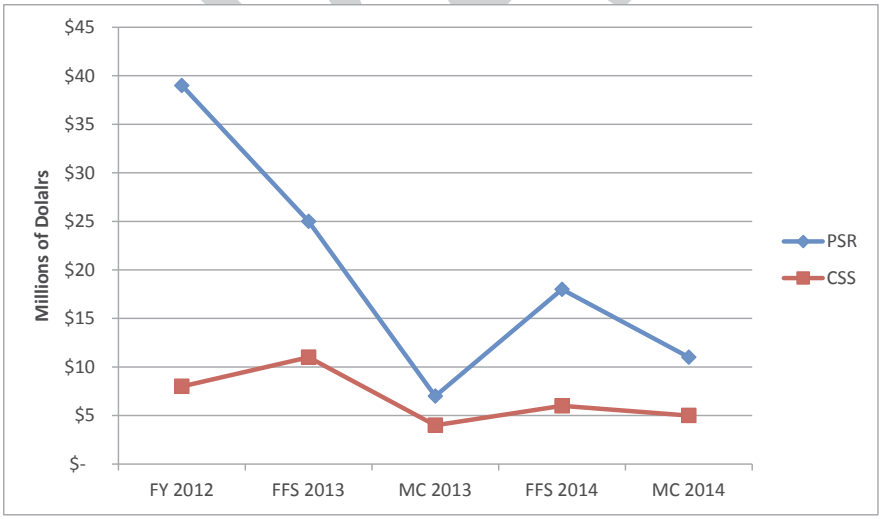
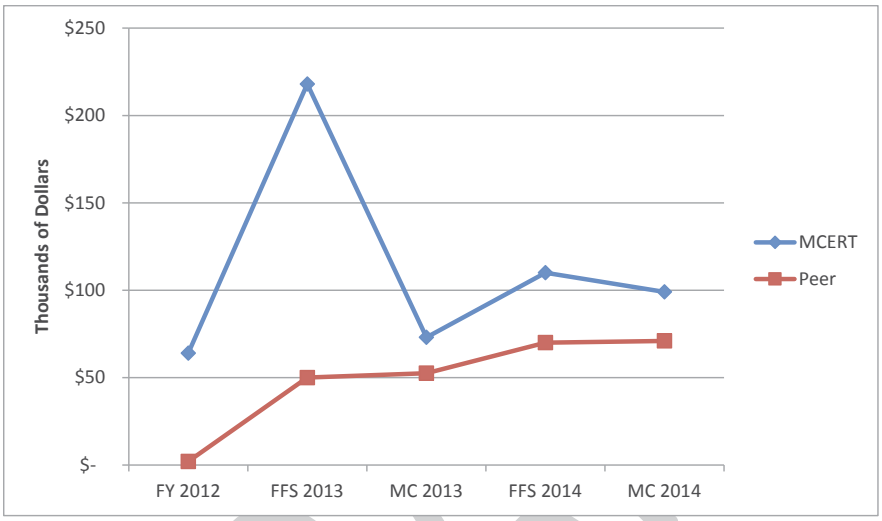


Figure 11: Total Medicaid Expenditures for MCERT and Peer



One of the most striking impacts of implementing managed care is on the funding of PACT services. PACT is intended to serve those individuals who are difficult to engage, utilize high cost services, and have poor treatment outcome - factors which may contribute to a preference by managed care organizations to increasingly rely on prior authorization. CMHCs described the prior authorization process for PACT services as "restrictive" and "burdensome," re-directing the team members from providing intensive services to recipients to completing paperwork. The teams were originally funded with DMH grant funds with the intent to bill Medicaid as the services matured. Figures 12 and 13 depict the opposite picture.

Figure 12: Users of Medicaid Reimbursed PACT Services

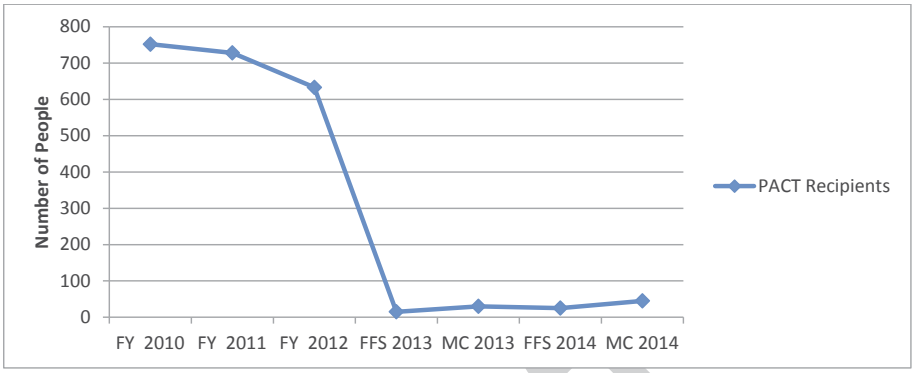
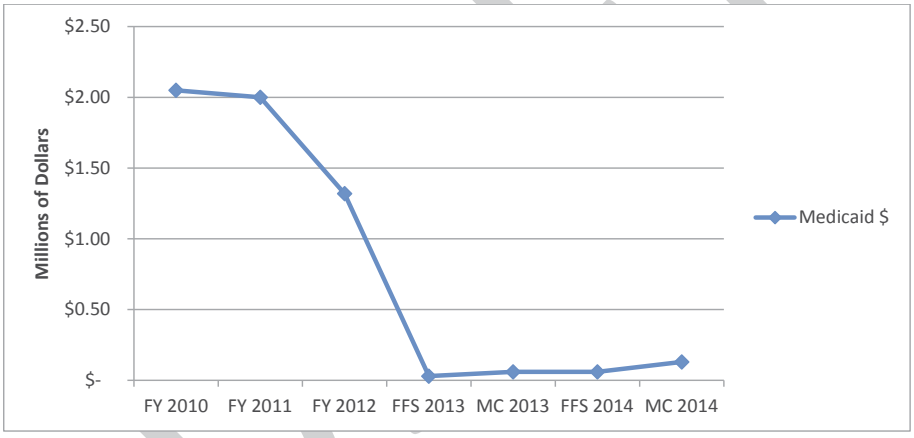


Figure 13: Medicaid Expenditures for PACT Services



The reportedly stringent authorization requirements and burdensome paperwork have resulted in CMHCs continuing to rely on DMH grant funding to provide PACT services to a limited number of adults rather than bill Medicaid for services and use DMH funding to expand the service to others in need.

Since the inception of managed care there are less Medicaid funds supporting community based mental health services.

Table 9: Total Medicaid Spend for Community MH Services in Millions

Commented [SS2]: The years dropped off the chart

	2010						
	FFS	FFS	FFS	FFS	MC	FFS	MC
				$54	$19.7	$34.2	$30.1

All Outpatient	$73.7	$81.1	$82.6	$73.7	$64.3

Service Limits

Payment limits on services such as PACT, Mobile Crisis Response, and Peer Support are contradictory to best practice since these services help to support individuals in the community and reduce over-reliance on more costly institutional or acute care. PACT is intended to be a long-term service that is available at the intensity and for the duration that meets the individual's needs. Mobile Crisis and Peer Support are intended to assist individuals by providing additional hands-on support in effort to mitigate admission to inpatient. There is no *clinical* rationale to arbitrarily impose service limits on these types of service that are more cost effective and have proven efficacy for their use. DOM does not maintain an Exceptions Process whereby additional services can be requested for individuals with documented need for continued treatment and support. Several CMHCs in fact indicated that they continue to provide care for individuals in need of service with no reimbursement after Medicaid limits have been reached.

Finally the inability to bill for more than one procedure on the same day creates a barrier to care. Many individuals who lack transportation struggle to get to a CMHC for an appointment and find it especially difficult to make a second trip for a service that they couldn't receive due to same day billing restrictions. This is especially problematic for the most rural areas of the state.

Rates

Medicaid reimbursement rates were also identified as problematic by the CMHCs. Rates are paid at 95% of the established fee, which creates an immediate shortfall. Additionally, rates do not take travel time or the rural nature of the state into account. An example is the rate for TCM and CSS – the rate for both services is the same. TCM is office-based; CSS is intended to be provided in the community in natural settings for the recipient and not in an office. Yet, there is no rate adjustment to account for the travel time from the CMHC to a recipient's home.

With Medicaid serving as the primary source of CMHCs' revenue, cost containment efforts impact accessibility to services for all. As described in the Children's Behavioral Health assessment, there are examples of ongoing cooperation between DOM and DMH. The sharing of policy changes before enactment, interagency agreements and memorandum of understanding are in place. However, agency goals are not always aligned which is impacting the behavioral health system.

Similar to the funding issues faced in serving children and youth with behavioral health needs, DOM is under tremendous pressure to manage costs in the Medicaid program. In an effort to meet that across the board directive, certain policies and rate decisions are implemented to meet that goal. However, these can have an inadvertent impact on the behavioral health delivery system and more importantly, on the individuals who are dependent on support from both DMH and DOM for their recovery

Workforce challenges

Workforce challenges facing both mental health and substance use are detailed in Chapter 3 of the Children's Report and will not be repeated here. As previously stated in this report, as of April 2012,

approximately 2.1 million Mississippi residents resided in a mental health professional shortage area with an estimated 1.1 of those residents considered "underserved."[47] In 2013 Mississippi ranked 46th in the nation for workforce availability.[48]

There are limited opportunities to support community settings in the recruitment and retention of psychiatrists in Mississippi. For example, psychiatry is not included as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program. In addition, telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, but is not being used to increase access to community psychiatric care. At the time of this writing, only one of the 14 CMHCs was actively utilizing telepsychiatry. Most CMHCs were not aware that there is grant funding available for the purchase of telehealth hardware or that codes have been established for billing the Medicaid program for telepsychiatry services. Finally, while Advanced Registered Nurse Practitioners are able and being used in Mississippi to augment psychiatric services, there appear to be some restrictions that limit their utility. ARNPs must have a collaborative agreement with a licensed psychiatrist and can only practice at a site pre-approved by the state Board of Nursing. [49]

DMH has responded to the shortage of licensed mental health clinicians by creating a certification process for non-licensed individuals working within the "state mental health system." The DMH Professional Licensure and Certification (PLACE) program was a creative attempt to appropriately respond to the shortage and should be applauded. Table 7 shows the number of individuals holding a DMH professional credential as of October 2014. The numbers below include staff with specific experience and interest in working with adults with serious mental illness as well as children with serious emotional disturbance.

Table 10: Number of individuals holding a DMH professional credential

Credential	Number as of 10/14/14
Mental health therapist	1,276
Community support specialist	964
IDD therapist	231
Licensed DMH administrator	79
Addictions therapist	111
TOTAL	**2,661**

Not all stakeholders view PLACE positively however; the Mississippi Psychiatric Association views the process as allowing services to be provided by "unqualified" staff. Absent the influx of more licensed professionals, DMH must either use this process to insure programs have sufficient staffing or face even greater issues with access to care in the public mental health system due to closures.

[47] Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437
[48] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
[49] http://www.msbn.ms.gov/Documents/AdministativeCode.pdf

To what extent are adults with mental health disorders and in recovery from addictive disease being utilized in the provision of mental health and substance use services?

DMH's peer support specialist certification program is a positive area of workforce development. Use of persons with lived experience in the provision of services is a strategy more states are using to augment traditional mental health services and support better engagement in treatment. Growing this underutilized workforce is a key to developing greater capacity to serve adults and families with behavioral health challenges. The certification process established by DMH and the inclusion of peer support in the state's rehabilitation option offers a positive opportunity for adults with lived experience. We do note however that the current peer support specialist application is complex and burdensome and the associated fees and training costs may hinder expanded capacity of this service.

In 2014, 62 individuals graduated from DMH sponsored Peer Support training.[50] The CMHCs reported providing Peer Support Services to 1,710 adults, but as indicated earlier in this report, there is considerable variation in the number of Peers hired across the CMHCs. While some providers report great success with the use of peer support in substance use residential programs, crisis stabilization, and mobile crisis services, others identified the low reimbursement rate for this service as a barrier to increasing service capacity, particularly for providers serving more rural areas. The Director of the Central Mississippi Residential Center has called upon Family advocates as well to augment her professional staff. Family advocates have been especially helpful in engaging families of residents who lack trust in the system to act in the best interest of their loved one. State-operated services would also benefit from employing Peer Specialists and Family Mentors to enrich their service delivery.

Finally, there is little to opportunity for mental health consumers and individuals in recovery from addictive disease to provide input into the behavioral health system. By statute , the nine-member DMH Advisory Board consists of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). These members are appointed by the Governor and approved by the state senate. While the current citizen representatives include parents of consumers, those most directly impacted by the service system do not have a voice at the table. Consumer input and influence at the state and provider decision-making levels are sorely missing throughout Mississippi's adult behavioral health system

Recommendations

A good and modern mental health service system provides ready access to an array of effective and efficient high quality services that support individuals in their communities and thereby alleviate the over-reliance on institutional care. Below are several recommendations intended to support and enhance provider capacity.

Address the inadequacy of funding for non-Medicaid eligible persons and services

The report identifies numerous examples of service inadequacy and barriers to care due to inadequate funding for community-based services and supports.

[50] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf

Absent a decision to expand Medicaid eligibility and enhance coverage, DMH should request that the Mississippi Legislature provide additional state funding, and/or establish a threshold of funding to be re-directed from state operated services, resulting in an increase in state general funding for CMHCs or other providers capable of providing services. States that have made progress strengthening their systems have done so through increased state funding and a re-allocation of institutional resources as the emphasis of care is shifted to the community. DMH should limit expenditure of the funds to expand service capacity as evidenced through data analysis.

In addition to seeking additional funding, DMH should assure that existing funds are spent properly. DMH should require CMHCs to bill Medicaid for all eligible services and recipients, and work with DOM to reduce excessive administrative burden. DMH should re-direct the funds made available toward expanding non-Medicaid eligible services. Similarly, DMH should establish an expectation that CMHCs re-direct any funds made available through the conversion of MH group homes or implementation of PSH back into funding for non-Medicaid eligible services/recipients.

If the State's policy is to continue to assign some financial responsibility to the counties, it should consider the need to increase the counties' contribution for mental health and substance use disorder services to ensure that residents have access to mental health services and related supports.

Promote Interagency Collaboration and Use of Data for Budgeting, Policy and Program Development

The Legislature should designate a responsible authority to oversee funding, policy and planning for both DMH and DOM, insuring that any decision takes into account the impact on both agencies to meet the needs of individuals. DOM has implemented a number of cost containment initiatives since 2010, resulting in approximately $10 million in *overall* savings to the Medicaid Program. Mississippi has the second highest rate of Federal Medicaid Participation (FMAP) in the country, about 73%. While the state saved about $3 million in state expenditures, it lost about $7 million in federal revenues. During this same time, as a result of initial DOJ findings in Mississippi, the Mississippi Legislature appropriated increases of $26 million to DMH, 100% state funds, for service expansion in 2014 and 2016. As a net result, Mississippi incurred increased state spending of $23 million and the loss of $7 million in federal revenue. While TAC is not advocating for generating federal revenues for the inappropriate delivery of services, this funding approach illustrates the absence of an effective strategy for the mental health system and for Mississippi taxpayers.

TAC is aware that DMH is hiring for a newly established Data Manager position. Adding this capacity is crucial for the agency. Informed with data, DMH and DOM should jointly review monthly service delivery and expenditure reports, monitoring for cost drivers that may need immediate attention. DMH should use data to assess the adequacy of Medicaid rates to incent community-based service delivery, thereby reducing the over-reliance on state hospitals. Documented evidence of insufficient rates impacting the availability of services must be addressed despite provider concerns. Finally, DMH should use data to assess the impact of service limits on the termination of, or reduced access to, needed services as well as the amount of uncompensated care provided by CMHCs. Documented evidence of

insufficient access to care must be addressed. At minimum there must be an Exception's Process to seek FFS authorization for needed services when limits have been exhausted.

DMH and DOM should collaborate with stakeholders and work together to establish a process and indicators to assess the quality of services funded across both agencies. DMH should be the state agency responsible for driving mental health policy for the State, and should be empowered to ensure that community service providers are held accountable for providing quality services that are consistent with best practices.

Address Workforce Challenges

DMH should expand the use of Peers to help in addressing the severe workforce shortages by allowing professional staff to devote their time strictly to the delivery of clinical services.

Mississippi should address the requirement that APRNs must establish individualized collaborative agreements with physicians. This issue was described in detail in the Children's assessment. In a rural state with few physicians such as Mississippi, collaborative agreements, especially those with proximity requirements, can significantly impede APRNs' ability to provide care. APRNs cite difficulty finding collaborating physicians that the Board of Medical Licensure would approve and that are located within a 40-mile catchment area of their practice. While Mississippi has made strides to ease these requirements in recent years, including an amendment to authorize a 90-day grace period for APRNs who cannot secure a collaborative physician, the geographic component of collaborative agreements is a major barrier that limits access to care.

DMH should explore opportunities or behavioral health internships to retain professionals in Mississippi post graduation. To address the need for behavioral health services and shortage of providers in rural Appalachian communities, Virginia established a behavioral health internship that is a partnership of two universities and a community health center. As of October 2014, the Stone Mountain Health Services Behavioral Health internship is into its fourth year of interns and has:

- 5 licensed clinical psychologists, including an assessment clinical psychologist
- 2 clinical psychology interns
- 2 licensed clinical social workers
- 1 masters' social worker, a product of the internship
- 1 social work intern
- 1 adult psychiatric nurse practitioner [51]

Quality

Consistent with the assessment of Mississippi's children's mental health system, our review of the adult services system also determined the lack of an approach to quality or quality improvement. DMH and

[51] http://www.raconline.org/success/project-examples/772

DOM gave consistent responses that they did conduct oversight of services and providers, consisting mainly of adherence to standards and requirements. However, these provider reviews were done for the purpose of assessing compliance as opposed to assessing the quality of care. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs. The purpose for the OSCR process is not only to assure compliance with state and federal requirements for Medicaid reimbursed mental health treatment, but to also assess services through direct observation, document review, staff interviews and interviews with service recipients and their families. DOM provides clear and specific feedback regarding their findings in order to enhance ongoing services. DOM plans to implement an OSCR process across all mental health services.

PACT serves as a case in point as to why compliance with requirements alone is not enough. PACT is an evidence-based approach and DMH monitors to insure that services are being delivered with high fidelity to service requirements. However, there are concerns with implementation of the service in Mississippi. The strict adherence to Fidelity appears at times to overshadow whether the service is improving the overall quality of life for recipients; the persons served appear at times to get lost in meeting the requirements.

As an example, one of the Legacy teams described a young woman who had participated in another service provided by the Region prior to agreeing to participate in PACT; she had established friendships and enjoyed the other programming but was assigned to PACT to reduce her repetitive inpatient admissions. Since assignment to PACT, the young woman has spent far fewer days in a psychiatric inpatient setting. But she is no longer able to attend the day programming that she enjoyed or to visit with her "friends." Her daily activities include free time, during which she now sits outside of the previously attended program and watches others inside. This team provides services with high fidelity to PACT standards and has significantly reduced inpatient utilization, but the recipient has lost a significant source of her social connectedness. Perhaps through the use of OSCR, strategies would be identified to enhance consumers' experiences with services.

Similarly to the Children's system review, TAC found that across DOM, DMH, and provider organizations there is limited use of data for planning purposes, to identify service gaps, or to assist managers in making day-to-day operational decisions. There is very little outcome data collected outside of federal grant programs or waivers. The data that is available is often outdated or has significant lags (i.e. claims data) making its utility for operational decisions limited. With a few exceptions, providers have limited data infrastructure and reporting systems are outdated and continue to rely heavily on paper and pencil reporting methods. In short, our review found there is no systematic way of looking at data across systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

In many of our interviews with family members, state agency staff, advocates, and providers concerns came up with respect to the quality of care. This is an issue described by all constituents, including those

that fund care, provide care or receive care. Stakeholders consistently described barriers to accessing needed services and supports, delays in obtaining necessary treatment leading to exacerbation in symptoms, lack of coordination among services, and ineffective care resulting in repeated hospitalizations, homelessness and criminal justice involvement. Apart from the MHS of Southern Mississippi's consumer-run drop-in center, there was little evidence that service recipients have meaningful input about the services they receive.

A positive development in Mississippi's system is that in 2012, DMH engaged the University of Southern Mississippi's School of Social Work (USM) to administer annual client satisfaction surveys for both adult and youth mental health services. In 2014, the third annual client satisfaction surveys were administered and questionnaires were completed by clients in each of the 14 Community Mental Health Center (CMHC) regions. The questionnaires include demographics and Likert style ratings for domains including access to services, treatment participation, appropriateness and quality of services, social connectedness, and skills improvement. Respondents also have the opportunity to answer open-ended questions regarding their satisfaction with the service system. In 2014, a total of Consumer Satisfaction Questionnaires were completed by clients receiving services in the 14 CMHC regions in Mississippi.

While positive in approach, there appear to be limited benefits from the surveys. The number of respondents is low… while 47.5 % of adults *receiving* surveys responded, that number represents 441 of 5,474 adults served on any given day. Using Peer Support specialists to assist with survey dissemination and collection may help to increase responses. More important, there is no indication of how the results are used to improve or enhance services. Service recipients may be more inclined to complete surveys if they know that their feedback will be used to enhance future service delivery.

Recommendations

Mississippi must improve its efforts to ensure: 1) the quality of services provided to individuals; and, 2) that services are consistent with best practices. Efforts must also empower DMH to hold providers accountable based upon performance measures, and to make decisions based on data. Following implementation of the Patient Protection and Affordable Care Act, the Center for Health and Human Services was charged with developing a National Quality Strategy (NQS), the purpose of which is to better meet the promise of providing all Americans with access to health care that is safe, effective, and affordable. In March 2011, the Secretary of HHS reported to Congress on a National Strategy for Quality Improvement in Health Care. Using the NQS as a model, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed the National Behavioral Health Quality Framework (NBHQF). The NBHQF provides a mechanism to examine and prioritize quality prevention, treatment, and recovery elements at the payer/system/plan, provider/practitioner, and patient/population levels. The NBHQF is aligned with the National Quality Strategy in that it supports the three broad aims of better care, healthy people/healthy communities, and affordable care. However, it was specifically broadened to include the dissemination of proven interventions and accessible care. SAMHSA offers the NBHQF as a guiding document for the identification and implementation of key behavioral health quality

measures for use in agency or system funding decisions, monitoring behavioral health of the nation, and the delivery of behavioral health care.[52]

The NBHQF is built around 6 measures of care: Effectiveness; Patient/Family/Community Centered, Coordinated; Healthy Living; Safe or Reduced Adverse Incidents; and Affordable/Accessible. The indicators within each measure are evolving and the subject of ongoing refinement. While not exhaustive, the following indicators would serve as a good starting point for DMH to consider.

Table 11: National Behavioral Health Quality Framework Measures of Care

Measures of Care	Indicators
Effectiveness	# of providers delivering EBPs, # of EBPs offered by each provider, # of individuals receiving EBPs
Patient/Family/Community Centered	# of individuals participating in satisfaction surveys, % of recipients participating in satisfaction surveys, % of providers sharing results with staff, # of actions taken in response to survey results, % of service recipients with documented assessment of housing needs, % of identified service recipients receiving assistance with accessing housing, % of service recipients with documented assessment of employment/education needs, % of identified service recipients receiving assistance with employment/education, % of individuals reporting social connectedness
Coordinated	post-discharge follow-up within 7 and 30 days, % of individuals discharged from any inpatient setting who's transitional care plan was shared with an aftercare provider, % of service recipients with medication reconciliation post discharge, % of individuals with documented assessment for a co-occurring mental health/substance abuse disorder
Healthy Living	% of service recipients with a WRAP, % of service recipients receiving basic health screens (such as weight, heart rate, blood pressure) at their BH provider, % of BH service recipients with at least annual encounters with a primary care provider and OB/Gyn for women, % of consumers who smoke offered cessation assistance
Reduced Adverse Incidents	hours of restraint, hours of seclusion, # of individuals discharged from any inpatient on more than 1 antipsychotic, % of service recipients assessed for exposure to trauma, % of identified recipients receiving trauma-informed care, % of service recipients assessed for suicide risk, & of service recipients with a crisis plan, % of service recipients receiving illness self-management
Affordable/accessible	# of individuals who decline to participate in treatment due to inability to pay; % of individuals who access treatment within standards for urgent, emergent and routine; % of individuals who access treatment without requiring involuntary commitment

[52] http://www.samhsa.gov/data/national-behavioral-health-quality-framework

Redefining the Role and Responsibilities for state hospital services in Mississippi

Viewing State Hospitals within a Continuum

While state hospitals are a significant provider of service in Mississippi, they operate as if apart from the rest of the mental health system. Interviews with treatment staff and the administration revealed a sense of "we" versus "them" when discussing the state hospital and the community. Hospital leadership conveyed pride in the scope and quality of services they provide to patients, and are of the opinion that individuals are not likely to obtain as comprehensive an array of accessible and high quality services in the community.

Similarly, CMHC staff described having little to no relationship with the state hospitals. Some send case management or crisis staff to the hospitals to participate in discharge planning for individuals known to their Centers, but others don't provide any services to individuals while hospitalized since they can't bill for the service and may have significant staff downtime due to travel.

There appears to be little communication between the state hospital administration and the CMHC Directors. State hospital staff reported that they don't hold meetings with the CMHCs and there appeared to be little interest in working with the CMHCs or to understand their strengths and needs. Staff indicated that CMHC Directors were too busy and would not travel to the state hospital for a meeting. Most of the hospital staff had little familiarity with the county-based services or the challenges CMHCs face in providing services. Absent communication there is no opportunity to discuss gaps that hospital staff may see in the community or the potential for sharing successful strategies and resources. Given its role as the state mental health authority, DMH should require this to occur.

As the agency responsible for the mental health system, DMH should articulate a vision for the state hospitals within the continuum of care. It is commendable that the hospital administration and staff take pride in their services, but it's unfortunate that they don't see the lack of access to comparable services in the community as a problem. Admission to a state hospital removes an individual from his or her home, family, friends and community, causes disruption in his or life and carries stigma. Many key informants throughout the system described the hospital as the "safety net"…the place where people with no health care coverage can receive mental health inpatient or substance abuse residential treatment. The hospital should be the last line of defense in stabilizing a mental illness or addiction, not the primary option for treatment.

Reducing Re-admissions

DMH has worked over the past few years to significantly reduce the length of stay for admissions, especially individuals served on the Receiving Units. This trend mirrors states across the country and is considered a best practice when the comprehensive array of community-based services and supports are readily available. Absent home and community based services, individuals may not transition well to the community, with little engagement and follow through with aftercare services. Using a point in time count for the hospital census in November, 2014, data on the number of state hospital patients who had a

previous state hospital admission reveals that the state hospital serves as a "revolving door" for many adults.

Table 12: Per Cent of Census on November 30, 2014 on Receiving and Continued Stay Units with a State Hospital Readmission(s)

	MSH		EMSH		NMSH		SMSH	
	Recvg	Cont St	Recvg	Cont St	Recvg	Cont St	Recvg	Cont St
1 readmission	15.53	14.47	50.00	0.00	15.00	N/A	17.00	N/A
2-5 readmissions	28.16	40.79	44.00	0.00	15.00	N/A	34.14	N/A
6-10 readmissions	16.02	17.11	6.00	0.00	2.00	N/A	4.87	N/A
10+ readmissions	11.65	13.16	0.00	0.00	17.00	N/A	0.00	N/A

The role of Private Psychiatric Hospitals and Psychiatric Units in Med Surge Hospitals

According to the 2013 Report on Hospitals from the Mississippi Department of Health, Division of Health Facilities Licensure and Certification[53], there were 588 adult psychiatric beds in Mississippi located in free-standing psychiatric hospitals and on psychiatric units of med/surge hospitals. In addition, there were 238 adult chemical dependency beds. Reportedly, these beds are only accessible for individuals with health insurance or the ability to private-pay leaving a large number of uninsured individuals without access to this service; with occupancy rates of 55.97% and 23.24% respectively there is bed capacity to treat more individuals in the community if there was a funding source. The lack of Medicaid coverage for substance abuse services is a clear barrier to accessing community treatment. The inability to access inpatient acute care psychiatric beds and alcohol and drug residential treatment beds in the community, especially for individuals presenting with challenging behaviors and no healthcare coverage, results in the state hospitals serving as the only option for treatment.

Workforce Issues for State Hospitals

While there is an obvious shortage of psychiatrists working in community mental health settings, particularly in more rural areas, State hospital administrators also cited challenges with maintaining staffing levels required for accreditation. The hospitals compete with the Veterans Administration and state prisons for psychiatrists, and in turn, the CMHCs compete with the hospitals. State hospital psychiatrists lamented the inability to hire additional psychiatrists via the federal loan forgiveness program, an option that was available in the past and enticed some of the current staff to their positions. Recruitment and attainment of direct care workers is also an issue for the hospitals. As one administrator pointed out the salaries for direct care staff are barely above minimum wage, yet these staff spend the most time with the patients, some who present with extremely challenging behaviors.

Funding

Advocates within the community perceive the state hospitals as flush with funding, which administrators were quick to challenge. Hospital budgets have also seen reductions in recent years. Mississippi's state hospital capacity was reduced by 286 beds from 2005 to 2010, from 49.7/100,000 population to

[53] http://msdh.ms.gov/msdhsite/_static/30,0,83.html

39/100,000.[54] The state still had the highest bed capacity per capita; South Dakota was second with 29.2 beds per 100,000 population. While operating budgets have been reduced, the grounds and facilities are deteriorating and have required extensive funding for repairs. The Legislature has secured more than $80 million in financing for needed capital construction and improvements. However, reliance on institutional care is inconsistent with best practices, and is fiscally unsustainable due to the significant expense of providing clinical care and maintaining aging facilities.

Recommendations

DMH must define the role and responsibilities for state hospitals within Mississippi's continuum of mental health service delivery. State hospitals should not be viewed apart from the community mental health system or as an adversary to CMHCS. Facilitating quarterly meetings/conference calls between state hospital administration, treatment teams and CMHC Leadership should help to enhance communication and problem solving for patients with complex needs and/or repeated hospital admissions. In Pennsylvania State Hospital Service Areas plan for requesting and using resources to enhance services and supports in both the communities and the hospital.

DMH has indicated support for the development of an accessible, community-based system. States that have committed to this have also committed to reducing reliance on long and short term inpatient care thus reducing state spending on institutional care. Several states have received "bridge funds," a significant investment in community-based services allocated by the legislature over a period of time (e.g. 1 – 5 years) with the intent to downsize and reduce appropriations to state hospitals as beds are utilized less. Savings are not realized by a reduction of one bed, but savings can be realized as increased numbers of vacant beds materialize. Key in this process is commitment to community services and hospital diversion, and to not unnecessarily fill state hospital beds as other patients move into community-based settings.

DMH must assure that if state hospitals are going to continue as part of the service continuum, services must be delivered in safe settings, availing current technology and staffed by qualified individuals who are adequately compensated. Direct care staff should receive wages and benefits sufficient to promote retention and afforded opportunities for advancement. Buildings which present safety concerns as well as inefficient and undesirable environments should not be used for patients. However, securing $80+ million is bonds for capital improvements in lieu of funding community-based care is hard to justify.

By creating a variety of opportunities for state hospital psychiatrists to serve as consultants for family physicians and other primary care providers, DMH will enhance the community's capacity to evaluate and treat adults with SMI. Project Echo[55], adapted from the model that originated in New Mexico, has proven very successful in enhancing the expertise of primary care providers in treating individuals with mental health disorders in rural communities. Other states and health plans have experienced similar success through regularly scheduled "grand rounds," where specialists conduct regularly scheduled case reviews with general practitioners, increasing their comfort level and expertise in treating more challenging, complex cases.

[54] http://www.tacreports.org/trends-in-availability
[55] http://www.rwjf.org/en/grants/grantees/project-echo.html

DMH should also look to address state hospital workforce issues through pursuing the loan forgiveness program as approved by the Legislature, and the hiring of Peer Support Specialists and Family Mentors to support the clinical staff.

DMH and DOM should crosswalk the state hospital, Medicaid and third-party formularies and address discrepancies. DMH should work with DOM to develop a process to advocate for access to high-cost medications when proven to be the only agent successful for treating an individual's mental illness. DMH should also explore bulk purchasing with the CMHCs to obtain reduced pricing for more costly medications.

DMH should assess the impact of issuing a policy prohibiting the admission of any individual directly to a state hospital if a CSU bed is available, can meet the clinical needs of the individual and assure the safety of the individual as well as the community. While DMH may not be able to control the decisions made by Chancery Court Judges they can take a stand on the rights of individuals to access less restrictive alternatives to care when available. In addition to assuring individuals have access to CSU beds when appropriate, DMH should also identify funding to negotiate for access to acute care beds when available in the community.

In order to address readmissions, DMH and DOM must resolve the inability to pay for TCM and CSS services while adults are inpatient, the use of mobile services capacity and "peer bridgers," and the timeliness, frequency and intensity of services for individuals who are in crisis or just transitioning from inpatient to community-based living. DMH should also conduct a thorough analysis of individuals with high numbers of readmissions to identify potential gaps in aftercare for the individuals, as well as the community based system. Addressing those factors should significantly reduce the revolving door.