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Mental Health in Mississippi: Analysis and Recommendations

Harvard Law School Mississippi Delta Project

March 2014

Acknowledgements

Throughout this report, we refer to information obtained from a variety of people who have first-hand experience with Mississippi's mental health system.[1] We are grateful to these individuals for taking the time to speak with us and share their experiences with the state's mental health system. We would also like to thank the Southern Institute for Mental Health Advocacy, Research, and Training (SMHART). SMHART played a key role in connecting us to members of Mississippi's mental health community and guiding the development of this report.

[1] This report was prepared by Kevin Golembiewski, member of the Harvard Law School Mississippi Delta Project, under the supervision of Nathan Rosenberg, Director, Delta Directions Consortium, and edited by Katherine Record, Senior Fellow, Center for Health Law & Policy Innovation of Harvard Law School. The following students from the Harvard Mississippi Delta Project were involved in the research and drafting of this report: Anne Augustine, Sabreena El-Amin, Stephanie Berger, Jon Cioschi, Josie Duffy, Alana Kirkland, Lisa Lana, Abbey Marr, and Christian Yost.

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Prologue

Thousands of Mississippians struggle with some type of mental illness, and their experiences illustrate that mental health is more than just a medical issue. Mental health has a profound impact on Mississippi's economy and overall standard of living; it is deeply connected to education, unemployment rates, crime, drug use, and public assistance. Given the far-reaching impact of mental health, it is important that all stakeholders (e.g., mental health professionals, state legislators, local policymakers, educators, attorneys), have access to detailed information about the current state of Mississippi's mental health system as well as an in-depth analysis of the system's most pressing issues.

The goal of this report is to assist stakeholders in their efforts to improve Mississippi's mental health system by providing such information and analysis. In addition to offering a nuanced look at mental health in Mississippi and identifying key issues the state faces, this report offers a series of recommendations for addressing such issues. Each section of the report provides recommendations for improving Mississippi's provision of mental health services and subsequent outcomes. These recommendations are geared towards policymakers, service providers, and non-profit leaders.

When reading this report, it is important to keep its context in mind. A recent study conducted by the National Alliance on Mental Illness (NAMI) measured the effectiveness of each state's approach to mental health, and issued most states a grade of a D or lower.[2] With the entire nation struggling to meet the needs of the mentally ill, many of Mississippi's problems are in fact national problems.

Why now?

The United States (U.S.) Department of Justice (DOJ) recently investigated Mississippi's mental health system, bringing heightened attention to mental health in the state.[3] As a result of the investigation, DOJ mandated that the state take certain actions to enhance its system of community-based care. This federal attention can be leveraged by stakeholders to ensure that mental health becomes a priority in the state. Furthermore, the DOJ's investigation includes a wealth of information that can be utilized by stakeholders as they work to better address the state's mental health needs.

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[2] *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, Nat'l Alliance on Mental Illness (November 5, 2011), http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009.

[3] A summary of the DOJ's findings and conclusions can be found at: *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, Justice.gov (May 28, 2012), http://www.justice.gov/crt/about/spl/documents/miss_findletter_12-22-11.pdf.

I. Introduction

A. The Impact of Mental Illness in Mississippi

Of the approximately 2.9 million residents of Mississippi, about 125,000 adults and about 34,000 children live with serious mental health conditions (e.g., schizophrenia, major depressive disorder, obsessive-compulsive disorder, bipolar disorder, panic disorder, post-traumatic stress disorder, borderline personality disorder).[4] In 2010, 27% and 40% of adult males and females, respectively, and 31.3% of whites and 37.7% of blacks in Mississippi, reported poor mental health (not amounting to a serious mental illness, or SMI).[5]

The inadequate treatment of mental illness can have costly consequences. The National Alliance on Mental Illness (NAMI), a non-profit grassroots mental health organization focused on improving the lives of those suffering from mental illness, states that the national economic cost of untreated mental illness is more than $100 billion each year.[6] Although not always outwardly perceptible, mental illnesses greatly disrupt a sufferer's "thinking, feeling, mood, ability to relate to others and daily functioning."[7] In severe cases, ordinary tasks such as getting out of bed or going to school and work become so difficult that a person may simply stop doing such activities. For example, during the 2006-2007 school year, 43% of Mississippi students aged fourteen and older living with serious mental health conditions and receiving special education services dropped out of high school.[8] This lack of education often leads to societal setbacks such as unemployment, substance abuse, homelessness, and incarceration. In 2008, there were 5,200 adults with mental illnesses incarcerated in Mississippi.[9] With proper treatment for their illnesses, many of these Mississippians would not be criminals, reducing costs and improving productivity.

Another detrimental consequence of mental illness is suicide. Nationally, a person commits suicide every 15.8 minutes.[10] Suicide is the eleventh-leading cause of death for all people in the U.S. and is the third-leading cause of death among people aged 15-24.[11] According to NAMI, "325 Mississippians died by suicide" in 2006.[12] Between 1999 and 2007, 302 young people aged 11 to 21 died by suicide in the state.[13] The majority of these deaths result from untreated mental illnesses (e.g., schizophrenia, major depressive disorder) and are thus preventable.[14]

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[4] *State Statistics: Mississippi* (2010), NAMI State Advocacy 2010 (November 5, 2011), http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93503.
[5] *Poor Mental Health Among Adults-Mississippi* (2010), Kaiser State Health Facts (November 5, 2011), http://www.statehealthfacts.org/profileind.jsp?ind=93&cat=2&rgn=26.
[6] *NAMI - About Mental Illness,* National Alliance on Mental Illness (November 5, 2011), http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm.
[7] *Id.*
[8] *State Statistics: Mississippi* (2010), *supra* note 4.
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *TeenScreen's Mississippi Adolescent Mental Health Fact Sheet,* TeenScreen National Center for Mental Health Checkups at Columbia University (February 2011), http://www.teenscreen.org/states/mississippi-adolescent-mental-health-fact-sheet/.
[14] *NAMI - About Mental Illness, supra* note 6.

B. How Effective is Mississippi's Mental Health System?

One method of gauging the efficacy of Mississippi's mental health system is to compare it with other states with similar resources and demographics, such as Alabama and Louisiana. Comparatively, Mississippi appears to be doing reasonably well in some areas. In 2010, Mississippi's public health system provided services to "49 percent of adults who live with serious mental health issues."[15] That year, Louisiana's public health system provided services to only 17 percent of adults living with a serious mental health problem.[16] Alabama provided services to only 33 percent.[17] Additionally, in 2006, Mississippi spent "$110 per capital on mental health agency services,"[18] while Louisiana spent just $61 per capita and Alabama spent $64 per capita.[19] However, a deeper look into Mississippi's mental health system reveals there are several aspects of Mississippi's approach to mental health that could be improved upon.

NAMI evaluates each state's mental health system every three years and gives grades to the states based on its evaluations, providing an in-depth analysis of Mississippi's mental health system. NAMI's grades are based on evaluations of four categories:

(1) health promotion and measurement (e.g., use of evidence-based practices and programing, emergency room waiting times, number of psychiatric beds);
(2) financing and core treatment/recovery services;
(3) consumer and family empowerment (access to information, consumer-run programs, family and peer education and support); and
(4) community integration and social inclusion (e.g., degree of collaboration among state mental health agencies).[20]

To evaluate each state's mental health program, NAMI conducted a web-based survey for consumers in each state, using a "snowball sample," in which mental health system users participated and were then asked to forward the survey to other eligible people.[21] It requested information from state programs on the provisions of services, and supplemented the information it received with data from several secondary sources.[22] Mississippi is one of the six states that received an F in 2009 from NAMI, while Alabama and Louisiana both received D's.[23] In addition, according to NAMI, Mississippi's system is regressing; it received a D in 2006.[24]

NAMI acknowledged that Mississippi was working to improve its services; Mississippi has opened seven community mental health crisis centers since 2006, has provided grants to fifteen community mental

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[15] *State Statistics: Mississippi* (2010), *supra* note 4.
[16] *State Statistics: Louisiana* (2010), NAMI State Advocacy 2010 (Nov. 5, 2011), http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93496.
[17] *State Statistics: Alabama* (2010), NAMI State Advocacy 2010 (Nov. 5, 2011), http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93478.
[18] *State Statistics: Mississippi* (2010), *supra* note 4.
[19] *State Statistics: Alabama* (2010), *supra* note 17.
[20] *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, *supra* note 2.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*

health centers across the state, and is implementing a crisis intervention team program in several counties.[25] However, NAMI still identified serious deficiencies in the area of appropriate community-based services and supports, which has resulted in overcrowding in psychiatric hospitals and a disproportionate representation of the mentally ill in jails and prisons.[26] A recent Department of Justice (DOJ) investigation confirms this analysis, as the DOJ found over-institutionalization in the state and the state's system of community-based services to be ineffective.[27]

According to the U.S. Center for Mental Health Services, Mississippi has a higher percentage of both adults and children utilizing mental health services than the U.S. average.[28] In serving these populations, Mississippi has a lower rate of state hospital re-admissions within both 30 and 180 days than the U.S. average, and a consumer satisfaction rating about on par with the average.[29] However, the data Mississippi provided on evidence-based programming showed a much lower participation rate for these types of programs in 2010 than the national average, corroborating NAMI's claim that the state's services are lacking compared to the rest of the nation.[30] In other words, Mississippi appears to do reasonably well with the few services it does provide, but the lack of breadth in resources it makes available to those in need makes it one of the nation's least successful states in dealing with residents' mental illnesses.

II. The Structure of Mississippi's Mental Health System

This section is designed to provide a detailed overview of how mental health service delivery is structured in Mississippi in order to provide a better understanding of the state's mental health system and the context for the rest of the report.

The structure of Mississippi's mental health system is similar to the structure of many other states' mental health systems. In Mississippi, this organization is called The Mississippi Department of Mental Health (DMH) oversees all state run mental health services (community based and institutional). DMH directly oversees state mental health institutions and delegates the administration of community services to private providers. While variation exists among the state as to the number of private providers serving a given catchment area, this general structure is relatively uniform.

A. Community Based Services

This section begins with a brief overview of the organization of Mississippi's system of community based mental health services. It then focuses on the key components of the system, including the system's funding, the administration and oversight of the system, and the services that the system provides. Lastly, there is a discussion of the various structural barriers that the system faces with respect to the effective provision of its services.

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[25] *Id.*
[26] *Id.*
[27] *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3.
[28] Ctr. for Mental Health Services & Nat'l Research Inst., Mental Health Cmty. Services Block Grant: 2010 State Summary Report.
[29] *Id.*
[30] *Id.*

Organization

In Mississippi, community based services are delivered through regional community mental health/mental retardation centers.[31] The state is broken up into fifteen regions, each of which has its own regional center. Regional centers provide a number of community based mental health services, as well as substance abuse and intellectual/developmental disabilities services.[32] Regional commissions supervise the centers and the Mississippi DMH is "responsible for certifying, monitoring, and assisting the regional community mental health centers."[33] The structure for this system of community care was put forth by the Regional Commission Act in 1966.[34]

In 1972, the Mississippi state legislature amended the Regional Commission Act in order to address growing concerns over institutionalization of people with mental illnesses, mental retardation, and/or intellectual disabilities.[35] Importantly, this amendment did not establish any state authority to create and manage community treatment facilities; rather it provided a structure by which counties could do so at their own discretion. The statute directs counties to appoint representative members to the regional commissions mentioned above.[36] Other southern states, such as Kentucky,[37] Alabama,[38] and Arkansas[39] follow a similar set-up. They each divide their state into regions then appoint regional representatives that contract with private providers. These states are also struggling to meet the needs of people with serious mental illnesses, receiving an F, D, and F, respectively, on NAMI's 2009 "Grading the States" report card.[40]

States receiving higher grades from NAMI organize community services in a similar fashion, but with certain innovations. For example, Maine, one of only six states to receive a B grade, created a system of Community Service Networks responsible for the oversight of community services in their respective catchment areas. Private providers can apply to participate in the network, but, unlike in Mississippi, no single provider can contract to provide all services for its region.[41] This organization has the potential to cover services beyond centralized areas because smaller organizations in more rural areas can apply for, and benefit from, membership in the community service network rather than one provider having to pay to expand to those areas.

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[31] Although mental illness and mental retardation are distinct medical issues, they are grouped together for the purposes of state administration.

[32] *Mental Health/Mental Retardation Centers*, Mississippi Dept. of Mental Health (January 19, 2012), http://www.dmh.state.ms.us/community_care.htm.

[33] *Id.*

[34] *Id.*

[35] Miss. Code Ann. § 41-19-33.

[36] *Community Care,* Miss. Dept. of Mental Health (November 5, 2011), http://www.dmh.state.ms.us/community_care.htm.

[37] *Ken. Dept. for Behavioral Health*, Developmental and Intellectual Disabilities (May 27, 2012), http://dbhdid.ky.gov/cmhc/default.asp?sub23.

[38] Ala. Dept. of Mental Health, Mental Illness Provider Directory, March 2011.

[39] Ark. Dept. of Human Services Div. of Behavioral Health Services (May 27, 2012), http://humanservices.arkansas.gov/dbhs/Pages/dbhs_services.aspx.

[40] *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, *supra* note 2.

[41] Office of Adult Mental Health Services, Community Service Network Memorandum of Understanding, Dec. 21, 2006.

As noted above, each of Mississippi's fifteen regions provides care through one major center, generally located in the most populated county. These regions can differ somewhat dramatically in terms of geography and wealth.[42] For example, Region 12 covers over five thousand square miles (twice the size of Delaware) and serves a population of 370,551, while Region 14 spans across just over one thousand square miles (the size of Rhode Island) and serves a population of 162,246. As discussed in Section III, the large size of some of the regions may act as a serious barrier to services due to transportation constraints.[43] Furthermore, difficulties resulting from large regions are likely exacerbated by the fact that some services are only available at a region's main center. The table below shows the population and geographic characteristics of all 15 regions:[44]

Characteristics of Community Care Regions

Region	Counties	Population	Square Miles	Median Household Income	Mean % Below Poverty Level
I	4	60,530	2057.41	25,812	34.53
II	6	175,728	3481.50	34,176	17.76
III	7	226,512	3569.52	34,787	19.96
IV	5	265,410	2173.24	36,767	23.05
V	4	91,604	2446.08	27,874[45]	37.98
VI	8	153,332	4657.59	24,239	33.50
VII	7	177,627	3513.30	30,747	27,07
VIII	5	328,641	3442.50	46,664	18.78
IX	1	245,289	869.74	36,751	23.30
X	9	244,467	5814.28	31,986	21.38
XI	9	149,530	4685.36	28,790	28.00
XII	9	370,551	5193.54	28,557	23.48
XIII	4	304,654	2304.09	40,372	18.86
XIV	2	162,246	1201.46	45,620	15.15
XV	2	76,838	1511.45	33,574	29.30

[42] *Mississippi – 2010,* US Census Bureau (November 5, 2011), http://quickfacts.census.gov/qfd/states/28000.html.
[43] The "Geographic Access to Services" section below expands on this issue.
[44] *See Mississippi – 2010, supra* note 42.
[45] Includes 2012 data.

Funding

Community mental health centers are non-profit entities that contract with individual regional commissions to supply community services.[46] Because they are not government agencies, they must pool funding from several sources, including state and federal grants, county taxes, fee for service reimbursement, and donations from outside sources.[47] While counties can levy taxes to benefit these centers at their own discretion, each county in a region must, under the Regional Commission Act, contribute a minimal amount of funds in order for the counties' Regional Commission to receive state money. This source of funding does not appear to create significant disparities in quality of services between wealthier and poorer counties. This is in part because several regions encompass counties of varying levels of income.[48]

Regional Commissions that are eligible to receive state funding must apply to DMH for such funding each year with the passage of a new state budget.[49] In addition, these Commissions receive state matching funds for Medicaid reimbursable community mental health services that their community mental health centers provide.[50] Community mental health centers can also access federal funding from the Community Mental Health Services Block Grant, which is administered by DMH.[51] Mississippi applies to the federal Center for Mental Health Services (CMHS) for block grant funding by submitting a plan for its use and an annual implementation report to ensure continued receipt of funds. In 2007, DMH received $4,103,232 from the grant, a small fraction of its total budget. This amount is based primarily on the population of the state.[52]

In 2007, DMH spent 44% of its budget on community mental health services.[53] Its neighbors allocated similar portions of their budgets on community services: Kentucky, 45.7%; Alabama, 50.2%; Georgia, 53%; and Arkansas, 37.7%.[54] The proportion of spending allocated to community care in these states is significantly lower than in states with better performing health systems (e.g., Maine, 66.7%; Maryland, 66%; Massachusetts, 83.4%; and Oklahoma, 63.5%).[55] In other words, apportioning more mental health funding to services delivered in the community, rather than in institutions, is correlated with improved outcomes.

Oversight and Administration of Community-Care Centers

Although the state does not directly manage community-care centers, it does play a role in their administration. The state's major responsibilities include planning and developing community mental

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[46] *Draft FY 2012-2013 State Plan for Community Mental Health Services*, Miss. Dept. of Mental Health (August 26, 2012), http://www.dmh.state.ms.us/pdf/FY%202012-2013%20MS%20State%20Plan%20for%20Community%20Mental%20Health%20Services%20pn.pdf.
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *How State Mental Health Agencies Use the Community Mental Health Services Block Grant to Improve Care and Transform Systems: 2007*, NASMHPD Research Institute, Inc. (June 5, 2012), http://www.healthcare.uiowa.edu/icmh/documents/MHBGReportSection508-5-6-08.pdf.
[53] *Id.*
[54] *Id.*
[55] *Id.*

health services, setting operational standards for the services it funds, and monitoring compliance with operational standards.[56] The state's role in setting operational standards is arguably its most important administrative function with respect to community mental health services because such guidelines ensure the quality and consistency of community services across the state.[57]

Because the state has delegated community based services to private providers, it can only ensure a uniform quality of care by setting standards, monitoring the implementation of those standards, and implementing appropriate consequences when those standards are not met. DMH is charged with developing the standards, which are then sent to the Secretary of State for approval.[58] DMH maintains a certification program in which it evaluates each community center every two years. Furthermore, DMH evaluates all applicants for mental health positions.[59] Community mental health centers receiving state funding must also submit monthly reports that outline service delivery and financial information.[60]

For adults, the operational standards mandate that each region must, at a minimum, provide: (1) outpatient therapy; (2) case management services; (3) psychiatric/physician services; (4) emergency/crisis services; (5) psychosocial rehabilitation; (6) inpatient referral; (7) family support and consumer education services; and (8) pre-evaluation screening for civil commitment. In order to ensure these standards are met, each Regional Commission is required to adopt an annual operations plan to be approved by the DMH.[61]

When DMH finds that a particular center has not met the operational standards noted above, the center's Regional Commission must submit an acceptable plan of compliance.[62] Failure to submit such a plan results in suspension and potential termination of certification.[63] If a plan is approved, however, no further action is required to receive certification and no action is taken to ensure that a center actually implements its plan.[64]

Services

Community based mental health services that are provided in Mississippi include general services, crisis-related services, and transition services. The state's approach to each of these types of services is outlined in this section.

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[56] *Draft FY 2012-2013 State Plan for Community Mental Health Services*, *supra* note 46.
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] The annual operations plan must include: (1) A description of funding for each minimum service component by major funding source (federal, state, local), (2) Targeted quantitative service levels planned for each minimum service component for the applicable fiscal year for which the Annual Operational Plan is being submitted (3) Targeted geographic area to be served (4) Brief narrative substantiating targeted quantitative service levels, clearly noting any increase, decrease or maintenance in current service levels (5) Projected funding by major funding source (federal, state, local) for implementation for each minimum service component targeted quantitative service levels (6) The provider must have a method to determine individual satisfaction with each service provided. The method of survey, the evaluation tool, and the results must be on file for review. *Id.*
[62] *Strategic Plan FY 2012-2016: Focusing on the Future*, Miss. Board of Mental Health & Miss. Dept. of Mental Health (August 26, 2012), http://www.dmh.state.ms.us/pdf/FY%202012-2016%20%20DMH%20Strategic%20Plan%20final.pdf.
[63] *Id.*
[64] *Id.*

Process for Accessing Services

To receive community-based services, one must go through a complex process. The consumer must bring identification and proof of insurance, Social Security, Medicare, and/or Medicaid with her to a mental health center.[65] After filling out the requisite paperwork, she will partake in an assessment. This initial assessment will take approximately 2 hours.[66] This process, relatively standard in many medical centers, can be daunting for an individual with severe mental illness (SMI), who has yet to have her symptoms addressed in a meaningful way. In addition, given the correlation between SMI and poverty, many of those needing community-based services may not be able to afford the time off from work or transportation needed to successfully complete this process.

General Services

General mental health services are services that can be used by a variety of consumers of mental health services; they are not tailored to certain types of illnesses. Such services include outpatient therapy, case management, family education and support services, prevention and early intervention programs, diagnostics and evaluation services, psychiatric care and medication monitoring, residential services, and day treatment. Once qualified, patients in nearly every region have access to a variety of such services. Most regions have diagnostic/evaluation services, general outpatient services, day treatment, case management, and some form of psychiatry.[67] However, many services do not seem to be provided consistently across regions. In particular, residential services and services related to youth in juvenile/dependency courts varies greatly from region to region.[68]

Crisis-Related Services

Acute Partial Hospitalization (APH) and Crisis Intervention Centers (CICs) are well-known resources for addressing mental health crises. These resources are important as they can effectively mitigate the potential effects of crises and also work to bring potential consumers into the community mental health system. APH refers to an intensive form of outpatient services in which individuals can utilize hospital programs such as medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy, while living at home. APH's can also facilitate integration into the community by providing a means by which individuals released from state institutions can continue to utilize institutional-type services while they adjust to living independently.

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[65] *FAQ,* Singing River Services (Nov. 5, 2011), http://singingriverservices.com/faq.html.
[66] *Id.*
[67] Phone interviews with representatives from Regions 1, 3, 9, 11, and 13 (September 4, 2012); Region One Mental Health Center (September 7, 2012), http://www.regionone.org/; Communicare (September 7, 2012) http://www.communicarems.org/index.html; Region IV Mental Health (September 7, 2012), http://www.timberhills.com/; Delta Comm. Mental Health (September 7, 2012), http://www.dcmhs.com/ ; Life Help (September 7, 2012), http://www.region6-lifehelp.org/index2.html), Region 8 Mental Health (September 7, 2012), http://region8mhs.org/; Hinds Behavioral Health Servs (September 7, 2012), http://www.hbhs9.com/; Weems Mental Health (September 7, 2012) http://www.weemsmh.com/ ; SW MS Mental Health (September 7, 2012), http://www.swmmhc.org/; Pine Belt Mental Health (September 7, 2012) http://www.pbmhr.com/; Gulf Coast Mental Health (September 7, 2012), http://www.gcmhc.com/; Singing River Servs (September 7, 2012), http://www.singingriverservices.com/; Warren-Yazoo Mental Health (September 7, 2012), http://www.warren-yazoo.org/.
[68] *Id.*

CIC's also provide services to individuals and families during emergencies. Mental health personnel that respond to crisis situations in the home or community often refer individuals posing a danger to themselves or to others to crisis centers, which provide temporary stabilization and monitoring during the crisis. After the crisis abates, personnel help facilitate the individual's re-introduction to the community system.

Despite the need for such these types of care, many Mississippians lack adequate access to APH and CICs. Only Regions 4, 6, 8, and 15 offer APH, and only seven out of the fifteen regions have CIC's (located exclusively in cities, putting them out-of-reach to most rural communities).[69] The lack of these services results in greater state expenditures and poorer health outcomes if individuals in crises end up institutionalized in state hospitals or jails.

Transition Services

As will be discussed below, Mississippi has relatively high rates of institutionalization, thus services that facilitate people's transition from institutions into the community are extremely important. Residential services, clubhouses, and Mental Illness Management Services (MIMS) are particularly effective transition services.

Residential services vary, but they often take the form of group homes or subsidized apartments operated under a general manager. These settings provide the advantages of proximity to treatment centers and accountability for medication compliance within an integrated and largely independent community setting. Twelve of the fifteen regions currently offer residential services specifically for adults with mental illnesses.[70] In Mississippi, these services typically include between two and four residences, located near the primary regional center, with capacities of about 15 to 30 people.[71] Given the importance of these residential services transitional programs, some Mississippians' transition back into their communities may be jeopardized by the lack of such programs in their region. Regions that do not have residential services can refer their clients to facilities in other regions, but the demand for residential services, coupled with insufficient supply, often leads to long waitlists.[72]

Clubhouses refer to psychosocial rehabilitation programs that focus on helping their members gain and keep employment. While clubhouses vary in the type and extent of the assistance they provide, all of the regions offer them, and they generally exist in multiple if not all of the counties within each region.[73]

MIMS provide a specific kind of case management directed toward those consumers with serious mental illnesses. They involve case managers with a higher level of expertise, often medical, and more indirect services designed to promote the transition to independence through programs related to

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[69] *Crisis Stabilization Units,* Miss. Dept. of Mental Health (November 5, 2011). http://www.dmh.state.ms.us/pdf/CSU%20Regions%201-5-11pdf.

[70] Interviews with representatives from each Regional Office (May 22 – May, 27, 2012).

[71] Region One Mental Health Center, *supra* note 67; Communicare; Region IV Mental Health, *supra* note 67; Delta Comm. Mental Health, *supra* note 67; Life Help, *supra* note 67; Region 8 Mental Health, *supra* note 67; Hinds Behavioral Health Servs, *supra* note 67; Weems Mental Health, *supra* note 67; SW MS Mental Health, *supra* note 67; Gulf Coast Mental Health, *supra* note 67; Singing River Servs, *supra* note 67; Warren-Yazoo Mental Health, *supra* note 67.

[72] Interview with Nikki Tapp, Region 4 Children Services Coordinator (May, 22, 2012).

[73] Interviews with representatives from each Regional Office, *supra* note 70.

employment, education, and domestic training. MIMS are currently available in only five regions.[74] Expanding residential services could make MIMS more accessible by concentrating the individuals most likely to need this type of care in locations nearby case workers and community centers.[75]

Transitional Services Offered by Each Region[76]

Region	Residential	Clubhouse	Acute Partial Hospitalization (APH)	Mental Illness Management Services (MIMS)	2012-2013 CMHS Block Grant Projected Funds
I		x		x	$99K
II	x	x			$126K
III	x	x			$114K
IV	x	x	x		$132K
V	x	x			$122K
VI	x	x	x		$146K
VII	x	x			$130K
VIII	x	x			$134K
IX		x		x	$141K
X		x			$138K
XI	x	x		x	$135K
XII	x	x			$151K
XIII	x	x	x		$137K
XIV	x	x		x	$101K
XV	x	x	x	x	$93K

Structural Barriers to Services

As a whole, community mental health centers offer a plethora of services to many Mississippians. However, the structure of Mississippi's system of community mental health centers leaves many individuals unable to access the community-based services they need.

[74] Region One Mental Health Center, *supra* note 67; Communicare; Region IV Mental Health, *supra* note 67; Delta Comm. Mental Health, *supra* note 67; Life Help, *supra* note 67; Region 8 Mental Health, *supra* note 67; Hinds Behavioral Health Servs, *supra* note 67; Weems Mental Health, *supra* note 67; SW MS Mental Health, *supra* note 67; Gulf Coast Mental Health, *supra* note 67; Singing River Servs, *supra* note 67; Warren-Yazoo Mental Health, *supra* note 67.

[75] *Mental Health/Mental Retardation Centers*, *supra* note 32; *Draft FY 2012-2013 State Plan for Community Mental Health Services*, *supra* note 46.

[76] Interviews with representatives of each Regional Office, *supra* note 70.

Poor spatial organization of services

Each region has only one primary center in its entire catchment area and one satellite center per county. This setup presents major issues with regards to case management services because each region's case workers, who travel to meet their patients in their homes, are likely based in their region's population centers and may have limited travel capacities. For example, Community Care Services in Region 7 provides case management services in only one city in each of the seven counties it is responsible for.[77] This setup has the potential to violate the mandate set forth by the state that each center provide minimum services throughout its entire catchment area because citizens living outside these cities may lack sufficient access to case management services.[78]

Furthermore, along with not providing services consistently within regions, community mental health centers do not appear to provide services consistently across regions. This inconsistency forces individuals to travel long distances in cases where they need services that are not provided in their region or a nearby region.

Limited amount of crisis-related services

Only eight out of fifteen regions have APHs or CICs. This limited amount of crisis-related services may be a key factor in Mississippi's overreliance on institutionalization. Due to a lack of statewide access to crisis-related services, many people may be placed into institutions when a crisis arises, even though, with proper crisis intervention, they could safely remain in their community.

Lack of Transparency Regarding Services Offered

Certain community service websites provide significantly very little information about services offered and others only broadly describe their services. For example, Region 3 has no listed website and Region 13's website states that its center provides "a full range of services for children with adjustment, behavioral, and learning problems" but does not specify what these are.[79] This raises the question of how well known and, therefore, available these programs actually are. However, this may not be a significant problem as many clients are referred to community mental health centers through schools and other organizations.

B. Institutionalization

In general, state institutions serve individuals with SMI. Mississippi fits this pattern; under state law, to receive institutional services, persons must have a substantial psychiatric disorder that grossly impairs functioning, disturbs behavior or perceptions, and poses a substantial likelihood of physical harm to self or others.[80]

As noted above, institutionalization plays a major role in Mississippi's mental health system. According to NAMI's 2009 Report on America's Health Care System for Adults with Serious Mental Illness,

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[77] *Services,* Comm. Counseling Services Miss. (November 5, 2011), http://www.ccsms.org/index.php?option=com_content&view=article&id=136&Itemid=182.
[78] *Strategic Plan FY 2012-2016: Focusing on the Future, supra* note 62.
[79] *Services,* Gulf Coast Mental Health Center (November 5, 2011), http://www.gcmhc.com/services.html.
[80] Miss. Code Ann. § 41-21-61.

Mississippi has a higher number of psychiatric beds per capita than any other state.[81] Over 4,300 people were institutionalized in Mississippi's five state institutions from October 2010 to September 2011.[82] Two private psychiatric hospitals, and 14 hospital-based psychiatric facilities provide another 540 beds at any given time.[83] In 2011, Mississippi's heavy reliance on institutionalization prompted the DOJ to begin investigating the state's compliance with the Americans with Disabilities Act, the Medical Assistance Act, and the Supreme Court's *Olmstead* decision. The investigation focuses on whether persons with mental illnesses are being served in an appropriately integrated setting.[84]

Funding

Mississippi spends a much larger portion of its mental health budget on institutional care than any other state. Mississippi has spent 55% of its budget on institutionalization in recent years, while, on average, other states have spent only 27%.[85] Such large reliance on institutional care is extremely expensive. Institutionalization costs approximately $150,000 per person per year in Mississippi.[86] This money comes from the state budget and fee for service programs – federal matching funds are not available through Medicaid for services delivered in institutions.[87] Although state funding is a vital source of revenue for mental health institutions, the Mississippi legislature has reduced its mental health budget by over $38 million from 2009 to 2011. This represents a sharp contrast from the state's neighbors Florida, Georgia, Alabama, Kentucky, and Arkansas, which each increased their mental health budgets during this time.[88]

Oversight and Administration of State Institutions

The Mississippi DMH is responsible for the oversight and administration of state institutions.[89] This approach to oversight and administration is common among states. In order to participate in Medicare or Medicaid programs, institutions must acquire certification from CMS. These standards apply nationwide.[90] The Joint Commission, an independent non-profit that evaluates hospitals based on health and safety standards, accredited Mississippi State Hospital and North and South Mississippi State Hospitals.[91]

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[81] *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3.
[82] *Id.*
[83] *Id.*
[84] Miss. Dept. of Mental Health, Dept. of Justice Update for Friends, August 15. 2011.
[85] *Id.*
[86] *Id.*
[87] *Id; United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3.
[88] *Id.*
[89] Miss. Code Ann. § 41-4-7.
[90] Centers for Medicare & Medicaid Services (May, 2012), http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html?redirect=/ CertificationandComplianc/.
[91] This certification is nationally recognized. Joint Commission (May, 2012), http://www.qualitycheck.org/consumer/searchresults.aspx?nm=Mississippi+State+Hospital&ddstatelist=&st_nm=-1&st=.

Services

Process for Accessing Services

Institutionalization occurs through voluntary admission or the civil commitment process. A person may voluntarily enter a state institution for treatment with the permission of the director if two medical professionals certify her need for treatment.[92] The civil commitment procedure is well organized. Any citizen can submit a request for treatment by making a sworn statement at the County Clerk's Office indicating strong evidence that an individual is a danger to themselves or others due to mental illness. Within 24 hours after the individual is taken into custody, she has a pre-evaluation screening conducted by two physicians or a physician and a psychologist, each certified by the DMH, at the county community mental health center. If the evaluators deem it necessary, the individual has a commitment hearing within 7 to 10 days, where they have a right to be present and a right to an attorney.[93]

If the court decides that inpatient treatment is necessary, the individual is brought to the nearest state hospital when space becomes available. If no space is available, the individual is kept at a nursing home, or as a last resort, in the county jail. Once space is available, a hospital treatment team reevaluates whether or not she needs to be admitted. After 20 days, the Chancery Clerk and the patient receive notice that the patient has 60 days to request a discharge hearing in writing. If requested, the hearing takes place at the hospital within 14 days. If the patient does not secure her own representation, the court appoints an attorney for her. Normally, a physician who has evaluated the patient within the last 10 days will testify. After judgment, the patient has a right to appeal the court's decision.[94]

People who do not meet the state criteria noted above regarding eligibility for institutional services are legally allowed to voluntarily go through the civil commitment process. However, because of restricted availability of beds and the priority given patients committed through court order, people who do not meet such criteria – as determined by a physician and affirmed by a Chancery Court judge – are likely to have an extremely difficult time accessing the system.

Services Offered

State institutions provide both inpatient and outpatient treatment for individuals suffering from mental illness, substance abuse, Alzheimer's disease, and other dementia. Mississippi State Hospital and East Mississippi State Hospital provide the bulk of these services, while North and South Mississippi State Hospitals and Central Mississippi Residential Center specialize in SMI and offer more limited inpatient treatment.[95]

Mississippi State Hospital offers acute psychiatric care, continued treatment services, and chemical dependency services. In terms of transitional services, the hospital provides limited outpatient therapy, a clubhouse program, supported and transitional employment, group homes, halfway houses, case management, and a homeless program. In total, the hospital served 4,699 consumers during FY 2011.[96]

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[92] Miss. Code Ann. § 41-21-103.
[93] Miss. Code Ann. § 41-21-73.
[94] Miss. Code Ann. § 41-21-63.
[95] *FY11 Annual Report*. Miss. Dept. of Mental Health (August 31, 2012), http://www.dmh.state.ms.us/pdf/FY%202011%20Strategic%20Plan%20Annual%20Report.pdf.
[96] *Id.*

East Mississippi State Hospital provides similar services with certain additions and exceptions. It offers intermediate psychiatric care, two nursing homes, and differentiates between adolescent and adult chemical dependency services. It does not provide supported and transitional employment, but it does have a center, the Friendship Center, offering outpatient, day care, and drop-in mental health services for community residents and the homeless. In total the hospital served 3,319 consumers during FY 2011.[97]

North Mississippi State Hospital provides inpatient services for adults with serious mental illness and served 575 consumers during FY 2011.[98] South Mississippi State Hospital provides acute psychiatric care. It served 546 consumers in FY 2011.[99] All patients at this facility were admitted via the civil commitment process.[100]

Finally, Central Mississippi Residential Center provides psychiatric services in a community setting with the purpose of reducing hospitalization and assisting consumers in making the transition to independent living in a community setting.[101] It includes four group homes that house a total of forty-eight men and women.[102] Residents' daily activities include housekeeping chores, meal preparation, and psycho-educational and skills-training groups. The Center attempts to engage with the surrounding community by opening its campus during the annual fall festival, providing mental health training to students and teachers, partnering with NAMI, and encouraging community members to volunteer.[103]

Central Mississippi Residential Center is a unique amalgamation of institutional and community-based care. As such, it has specific admission criteria that include a primary diagnosis of a serious mental illness, absence of active substance dependence requiring medical detoxification and a desire to maintain sobriety, medical and psychiatric stability, willingness and desire to take an active role in managing illness, a lack of recent acts of aggression or active thoughts of suicide, a desire to learn to self-administer medication, a desire to participate in structured daily activities, and a willingness to comply with house rules and duties. These criteria are necessarily limiting and exclusive. The residential center served 151 consumers in FY 2011.[104]

In terms of acute psychiatric services, Mississippi's state institutions appear to utilize a token economy.[105] A token economy is a system in which patients receive or lose privileges (e.g., phone calls, visitation) based on active participation in treatment, cooperation with staff, and lack of behavioral problems. This model is common among institutions throughout the country.[106] While a token economy can be very effective inside the hospital, its long-term efficacy is questionable because community life is not structured this way. As the DOJ put it in its investigative report, "this focus on

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[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] South Miss. State Hospital (May 20, 2012), http://www.smsh.state.ms.us/familyinfo.htm#admissions.
[101] Central Miss. Residential Center (May 22, 2012), http://www.cmrc.state.ms.us/services.html.
[102] *Id.*
[103] *Id.*
[104] *FY11 Annual Report, supra* note 95.
[105] Treatment, North Miss. State Hospital (Aug. 26, 2012), http://www.nmsh.state.ms.us/Treatment.htm; *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3 at 17-8.
[106] Robert Paul Liberman, *The Token Economy*, American Journal of Psychiatry (2000).

obedience and hospital rules is disconnected from the skills and individual needs in order to live safely and successfully in the community."[107]

Structural Barriers to Services

Unduly restrictive institutional access rules

Institutions are responsible for serving individuals within their catchment areas. While this ensures that individuals receive treatment in a setting closer to her home, it severely limits an individual's options. The director of any DMH facility has the authority to transfer any patient to another facility,[108] but it is unclear how often the provision is utilized. For example, East Mississippi State Hospital explicitly states that, due to large demand for services, it will not admit patients outside of its catchment area.[109] Given each institution provides different services, this may preclude some patients from being able to access needed services.

Lack of coordination between institutions and community health providers with respect to transition

The relationship between community mental health centers and state hospitals seems largely coordinated through monthly planning meetings. Each region has an intensive case manager attend these meetings at the hospital associated with their catchment area in order to plan for patient transitions into and out of the hospital.[110]

Such services are woefully inadequate according to the DOJ Report:

> In recent years, dozens of people with mental illness were discharged from one of the four State psychiatric hospitals with few, inadequate or no support services to meet their needs in the community, including personal care homes, halfway houses, shelters, or even the streets. Such settings do not provide…crisis supports, case management, transportation to medical appointments and community activities, and medication management.[111]

According to the DOJ report, community mental health centers are not involved in the treatment and discharge planning of patients, even though these centers are responsible for their treatment when they return to the community. Furthermore, the report states that Mississippi does little more than provide enough medication to last until the next psychiatric appointment.[112] Recently discharged patients with mental illness often require social and fiscal support both to maintain a pharmacologic treatment regimen as well as to secure housing, employment, or psychosocial services.

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[107] *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3 at 18.
[108] Miss. Code Ann. § 41-4-25.
[109] East Miss. State Hospital (May 19, 2012), http://www.emsh.state.ms.us/index_files/Page1826.htm.
[110] Interviews with Representatives from each region, May 22 – 27, 2012 (notes on file with authors).
[111] *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3 at 18.
[112] *Id.*

Institutional life not structured in a manner conducive to re-integration into the community

A major contributing factor to over-institutionalization in Mississippi may be the lack of programs in institutions that prepare patients for re-entering their communities. As noted above, all state hospitals use a token economy, which is "disconnected from the skills and individual needs in order to live safely and successfully in the community."[113] Given patients are not being treated in a system that allows them to develop or re-learn valuable life skills, periods of institutionalization last longer than necessary and a higher number of people may need to be re-institutionalized.

C. Recommendations

Contract with multiple community mental health service providers

As discussed above, several regional mental health centers are responsible for very large areas, creating issues with access to services. This occurs because Mississippi allows a single provider to contract for an entire region, thus preventing new entrants from filling service gaps. This obstacle to services would likely be attenuated if the state adopted Maine's approach and ensured that multiple services providers in each region could contract with the state. For example, if a current provider is failing to provide accessible services to a portion of the region because of cost concerns, a new provider may be able to enter the market and fill the services gap. Furthermore, allowing multiple service providers in a region ensures competitive pressure between providers that can benefit consumers. If a gap in services exist in part of a region, a current provider will be more likely to address such a gap if it is threatened by another provider's entry.

Increase transparency of services provided

Many community health providers' websites have few details about the services they provide. This lack of transparency about services provided may deter individuals from seeking treatment because it may lead them to believe that such providers do not have the ability to meet their needs. Furthermore, some people may be more hesitant to seek services when they have no guidance about the treatment process – a website with a detailed overview of services provided could provide such guidance.

Establish a statewide mental health first aid program

Mental Health First Aid (MHFA) courses teach people how to help someone experiencing a mental health-related crisis situation. MHFA courses are typically 12-hours and train "people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help."[114] Several states have statewide programs requiring certain public workers and citizens to complete training as part of their job.[115] For example, Missouri provides MHFA training opportunities to clergy and Rhode Island has made MHFA programs a part of police officer training.[116]

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[113] *Id.*
[114] *Governments Discover the Importance of Mental Health First Aid,* Governing (June 6, 2012), http://www.governing.com/topics/health-human-services/gov-governments-discover-mental-health-first-aid.html.
[115] *Id.*
[116] *Id.*

Adopting a statewide MHFA program could help ensure crisis-situations are effectively addressed throughout the state. Furthermore, such a program is relatively inexpensive – an MHFA course costs about $180, "which pays for instructor time, materials, classroom location and snacks."[117] Such costs could be decreased over time as more people become skilled in MHFA and can provide free training to their co-workers, neighbors, or friends.

Expand collaboration and coordination between institutions and community providers

By sharing information and resources, institutions and community providers can ensure they are addressing each patient's needs efficiently and effectively. Region 4 and the North Mississippi State Hospital's recent efforts exemplify the power of such collaboration; Region 4 expanded its relationship with North Mississippi State Hospital by acquiring facilities next to the hospital campus and by operating a crisis center within its catchment area.[118] This allows patients at the hospital to receive community-based services that the hospital may not provide. Furthermore, with a crisis center and hospital near each other, the hospital and the center can easily assist each other and share information about patients.

It is particularly important for community providers and institutions to coordinate transitional services. Institutions should provide information on patients' medicinal, psychosocial, and practical skill needs to community providers prior to each patient's re-entry into the community. Furthermore, these entities should work together to build a transitional plan for patients. Through such collaboration, community providers and institutions will have more information about their patients and, as a result, be able to more effectively tailor their services to their patients' needs.

Provide institutional programs that are geared towards preparing patients for re-integration into the community

Mississippi's state institutions can help decrease institutionalization by adopting programs that focus on preparing patients for re-entry into their communities. If patients develop and re-learn the skills needed to be successful in their communities at a quicker pace, they can spend less time in the hospital. Several states have adopted programs with such as focus. For example, New Jersey has "self-help" centers open at its state psychiatric hospitals that link current patients with consumers who are already successfully living in the community.[119] Such relationships allow patients to continue to be connected to their communities, witness successful community behavior, and provide patients with confidence that they can integrate into the community. Adopting such a program and moving away from a token economy could lead to cost-reductions and better health outcomes by reducing institutionalization across the state.

[117] *Id.*
[118] Interview with Nikki Tapp, *supra* note 72.
[119] *Self-help Centers Open at State Psychiatric Hospitals*, State of New Jersey Department of Human Services (June 4, 2012), http://www.state.nj.us/humanservices/news/press/2011/approved/20110526.html.

III. Geographic Access to Services

Poor roads, distance to health care providers, and lack of a consistent means of transportation all act as barriers to people seeking mental health services, especially in rural areas.[120] In 2008, lack of transportation kept almost 13% of all black Mississippians from pursuing medical treatment, and distance from a provider kept about 7% from receiving such treatment.[121] Geographic access is likely to be an even more serious problem for mental health patients because there are fewer mental health providers relative to other health providers.[122] Forty-five out of eighty-two Mississippi counties do not have a single practicing psychiatrist or psychologist.[123] Furthermore, patients are often reluctant to visit providers in their neighborhoods because of the stigma attached to mental illness (i.e., they prefer to maintain anonymity when seeking mental health care). The geographic spread of patients, combined with the reluctance to seek help locally, makes accessing care especially difficult.

This section begins with a discussion of the transportation options that patients in Mississippi currently have. Next, it provides a description of telemedicine, and outlines Mississippi's current use of this technology. Lastly, recommendations are given on ways to improve Mississippians' geographic access to services.

A. Transportation

Given the inconsistent dispersion of mental health providers across Mississippi and people's reluctance to visit neighborhood providers, reliable transportation is pivotal to many people's mental health treatment. Given a lack of widespread public transportation in the state, most Mississippians drive themselves to appointments.[124] However, depending on the severity of the illness, even those with cars may not always be in a condition to drive when they need medical services.[125] In addition, the cost of gas can make long trips prohibitive.

For those without access to a car, limited public transportation creates a serious barrier to receiving mental health treatment.[126] Many patients must rely on taxi service, which can be extremely expensive given dispersion of the population across the state.[127] To compensate, Mississippi provides transportation to mental health services in some circumstances. DMH requires community mental

[120] Jeanne C. Fox, Michael Blank, Virginia G. Rovnyak, & Rhoneise Y. Barnett, *Barriers to Help Seeking for Mental Disorders in a Rural Impoverished Population*, 37 Cmty. Mental Health Journal 421, 422 (October 2001).
[121] Lindsay Jones, Sangeetha Shivaji, Arthur G. Cosby, & Elliott Welford, *Access to Care,* Miss. State Univ. (Nov. 5, 2011), http://www.ssrc.msstate.edu/wp-content/uploads/6-access-091510SmallestSize.pdf.
[122] The U.S. Department. of Health and Human Services lists 141 Health Performance Shortage Areas (HPSAs) in Mississippi where there is a shortage of primary medical care providers and 181 for mental health. *Find Shortage Areas: HPSA by State and County*, Health Res. and Serv. Admin. (May 4, 2012), http://hpsafind.hrsa.gov/HPSASearch.aspx.
[123] Miss. Psychiatrist & Psychologist 2010, Miss. State Univ. Social Science Research Center (on file with authors).
[124] E-mail from Tonya Tate, Executive Director, NAMI Miss., to Anne Augustine, Harvard Law School student (Mar. 5, 2012) (on file with author).
[125] Miss. Psychiatrist & Psychologist 2010, Miss. State Univ. Social Science Research Center (on file with authors).
[126] E-mail from Tonya Tate, Executive Director, NAMI Miss., to Anne Augustine, Harvard Law School student (Mar. 5, 2012) (on file with author).
[127] *Id.*

health centers to regularly develop plans to ensure patients have access to necessary transportation.[128] DMH recently received a three-year planning grant from the state Division of Medicaid to develop a coordinated transportation system.[129] Some of such grant funding is being used by DMH to develop a pilot program in Region 6 (west-central Mississippi) to assess needs in the area and start a call-in center to provide transportation at a reduced rate for patients with disabilities.[130]

Federal regulations require states to have plans describing how their respective Medicaid agencies ensure that Medicaid patients have transportation to and from healthcare providers.[131] Mississippi contracts with a transportation broker to manage its non-emergency Medicaid transportation.[132] The state Division of Medicaid monitors the brokers.[133] Based on a Mississippi legislative report on Medicaid transportation from 2007-08, the system seems to be working as planned, providing timely service and denying service only for reasons authorized by the Division of Medicaid.[134] For example, brokers may deny service if patients have not arranged a ride at least three days before an appointment.[135] Due to this requirement, Mississippians on Medicaid may have to either use an ambulance or wait three days before they receive transportation for treatment.

Those not on Medicaid and not using a community mental health center may be able to find programs that provide free or inexpensive non-emergency transportation, but there are few such options in Mississippi. Area Agencies on Aging, part of the state Department of Human Services, provide adults over 60 with transportation services funded by the state Department of Transportation.[136] NTC Transportation, a for-profit company that acts primarily as a transportation provider through service contracts and for Medicaid patients, also states that it often provides free rides for those who are not on

[128] Edwin C. LeGrand III, *Mississippi Application for FY 2012-13 Community Mental Health Services Block Grant*, 40 (Aug. 26, 2011), http://www.dmh.state.ms.us/pdf/FY%20%202012-2013%20State%20Plan%20Block%20Grant%20Application%20FINAL.pdf: p. 40.
[129] *Adult Mental Health Community Services*, Mississippi Dep't. of Mental Health (May 5, 2012), http://www.dmh.state.ms.us/adult_community_services.htm.
[130] Of the $2,205,211 DMH requested in total from the federal Center for Mental Health Services, it requested $10,870 for this pilot program. LeGrand III, *supra* note 128.
[131] 42 C.F.R. §431.53; if a state is not complying with its plan, the Centers for Medicare and Medicaid Services (CMS), located in the Department of Health and Human Services, has the power to withhold federal funds. In reality, CMS has rarely, if ever, actually withheld funds due to non-compliance. Jane Perkins, *Medicaid: Past Successes and Future Challenges*, Health Matrix: Journal of Law-Medicine 7, 9 (Winter 2002).
[132] Sara Rosenbaum, Nancy Lopez, Melanie J. Morris, & Marsha Simon, *Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implication for Health Reform*, George Washington Univ. Med. Ctr. (Nov. 5, 2011), http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_377A5480-5056-9D20-3DF264AA41CFBDEC.pdf.
[133] Joint Legislative Comm. on Performance Evaluation and Expenditure Review, *A Review of the Mississippi Division of Medicaid's Non-Emergency Transportation Program* (Jan. 7, 2008), http://www.peer.state.ms.us/reports/rpt510.pdf.
[134] Joint Legislative Comm. on Performance Evaluation and Expenditure Review, *A Review of the Mississippi Division of Medicaid's Non-Emergency Transportation Program*, xiii, (Jan. 7, 2008), http://www.peer.state.ms.us/reports/rpt510.pdf.
[135] *Id*.
[136] *Div. of Aging and Adult Serv.,* Miss. Dept. of Human Serv. (Nov. 5, 2011), http://www.mdhs.state.ms.us/aas_info.html.

Medicaid, but cannot afford to pay for a ride to a medical appointment within the sixteen Delta counties it serves.[137]

B. Telehealth

'Telehealth' or 'telemedicine' involves providing medical services through electronics, usually with two-way video conferencing.[138] A telemedicine session is a doctor/patient session that allows the client to go to the clinic or hospital closest to her home and still see a specialist even if one is not employed at her respective clinic or hospital. For example, Louisiana has the state-funded Louisiana Rural Health Information Exchange (LaRHIX), which includes a center in Shreveport and 24 rural hospitals.[139] The hospitals "are connected via a tele-consultation network, which allows patients to access care from physicians in Shreveport without leaving their communities."[140]

Benefits of Telehealth

Telemedicine has several benefits in rural areas, besides being a way to reach patients who lack transportation. Telehealth increases consumer choice; this is especially important if the only local provider already has a personal relationship with the patient that would make it unethical for her to be the psychiatrist, if the patient does not get along well with the provider, or if the patient would feel more comfortable sharing information with someone outside of the local community.[141] Telehealth also has the potential to help the people who live with and care for patients; internet and video conferencing can provide education and support services to caregivers who do not have time or resources to travel to such services.[142] Lastly, there is evidence that telehealth may be more cost-effective than in-person care.[143]

Telehealth programs for mental health have been implemented in several states and such programs generally have had fewer missed appointments than traditional face-to-face visits.[144] Several studies

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[137] *Non-Emergency Transport Service*, NTC Transportation (Nov. 5, 2011), http://www.ntctransportation.com/non-emergency-transport-service/; *About*, NTC Transportation (Nov. 5, 2011), http://www.ntctransportation.com/about/.

[138] Jodi Polaha, *Behavioral Telehealth*, Neb. Dept. of Health and Human Serv. (Nov. 5, 2011), http://www.hhs.state.ne.us/Behavioral_Health/BHcommission/Final6_14_05Nebraska_Telehealth_Plan.pdf; *see also About ATA,* American Telemedicine Association (Nov. 5, 2011), http://www.americantelemed.org/i4a/pages/index.cfm?pageID=3281.

[139] Maureen McKinney, *Louisiana Reaps Health Gains with Telemedicine Strategy* (April. 8, 2009), http://www.govhealthit.com/news/louisiana-reaps-health-gains-telemedicine-strategy.

[140] *Id.*

[141] Polaha, *supra* note 138.

[142] Kathleen Coen Buckwalter, Linda Lindsey Davis, Bonnie J. Wakefield, Michael G. Kienzle, & Mary Ann Murray, *Telehealth for Elders and Their Caregivers in Rural Communities*, 25 Family and Community Health 31, 34 (October 2002).

[143] The University of Texas Medical Branch's telehealth program will save the state of Texas $4.28 billion per year over a four-year period by reducing transfers between hospitals, office visits, and redundant tests. *See* Alexander H. Vo, *The Telehealth Promise*, UTMB (May 11, 2012), http://telehealth.utmb.edu/presentations/The%20Telehealth%20Promise-Better%20Health%20Care%20and%20Cost%20Savings%20for%20the%2021st%20Century.pdf.

[144] Polaha, supra note 138.

have found that technical problems are rare and satisfaction, for both patients and providers, is high.[145] For example, in 2006, Texas instituted a telemedicine pilot program for Medicaid patients who need mental health care in underserved areas.[146] Telecommunications allowed these patients to access services from psychiatrists in other parts of Texas, and health outcomes were similar to those obtained from face-to-face services.[147]

Arizona has one of the oldest telehealth programs in the nation. The Arizona Telemedicine Program, using two-way videoconferencing for behavioral health provision, was created by the state legislature in 1996.[148] It coordinates the Department of Corrections, Veteran's Affairs, Indian Health services, hospital and nursing home services, and the University of Arizona health system.[149] The program expanded care to remote reservations in the north of the state and improved research and supervision of local providers.[150] Only 45% of the funding of Arizona's program comes from the state.[151] The rest comes from revenue and grants.[152]

Telemedicine has also found great success in places outside of mental health clinics and hospitals. The Texas prison system has created the "world's largest telemedicine system outside of the Pentagon."[153] The statewide system serves 120 state prisons, 15 youth prisons and three federal prisons.[154] Due to this efficient use of medicine, Texas has had a 45 percent reduction in unnecessary medical tests.[155] There has also been a 70 percent reduction in the number of transfers from prison facilities to physician offices and a 38 percent reduction in transfers from inmate housing to emergency rooms.[156] Overall, this program has saved Texas taxpayers nearly $1 billion dollars over the last ten years.[157] By implementing this kind of initiative, Mississippi could create a less costly and more effective mental health system.

Telehealth and Mississippi

The Delta Health Alliance, a non-profit focused on combating poor health in the Mississippi Delta, started a telemedicine program in Mississippi in 2008. The program connects fourteen community mental health centers, the Mississippi State Hospital, and specialists and the University of Mississippi Medical Center Department of Psychiatry and Human Behavior (UMMC), creating a robust telehealth

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[145] *See, e.g.* Buckwalter et al., supra note 142 at 33; Anouk L. Grubaugh, Gregory D. Cain, Jon D. Elhai, Sarah L. Patrick, & B. Christopher Frueh, *Attitudes Toward Medical and Mental Health Care Delivered via Telehealth Applications Among Rural and Urban Primary Care Patients*, 196 J. of Nervous and Mental Disease 166 (Feb. 2008).
[146] *Mental Health Telemedicine Services Pilot Program,* Dept. of State Health Serv. for the Health and Human Serv. Comm'n. (Nov. 5, 2011), http://www.dshs.state.tx.us/cpcpi/telemedicine.shtm.
[147] *Id.*
[148] Polaha, supra note 138.
[149] *Id.*
[150] *Id.*
[151] *Id.*
[152] *Id.*
[153] Bernie Monegain, *EMR, Telemedicine Saves Texas $1B* (Aug. 24, 2011), http://www.healthcareitnews.com/news/emr-telemedicine-saves-texas-1b.
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*

network.[158] Through the program, patients of participating community mental health centers can visit their centers and receive telehealth services from specialists at UMMC.[159] Furthermore, patients at the Mississippi state hospital can engage in family visits via video conferencing through the program.[160] Nearly all of the patients that responded to a survey of the program were satisfied and said that they would use the program again as well as recommend it to others.[161] The University of Mississippi also uses the telemedicine system to train providers in the community mental health centers.[162]

In addition to providing medical services through telehealth, medical information and chat services over the internet can provide a new way for people with mental health problems to seek help and information. People may to be less inhibited online than over the phone or face-to-face.[163] It is important to note, however, that Mississippi has a lower rate of internet access than any other state, with 55% of residents using the internet, compared to a national average of 68.4%.[164]

C. Recommendations

Make Dial-A-Ride services more accessible

Currently, Mississippians must reserve transportation via Dial-a-Ride, a public transportation program for those with disabilities and the elderly, three days in advance. This requirement acts as a barrier to individuals receiving services in emergency situations. Massachusetts only requires that reservations be made a day before it is needed, thereby allowing people to more quickly obtain services.[165] This can be especially important for mental health care, where individuals may lack the capacity to plan in advance, and may need services more immediately.

Create a volunteer driver program

A volunteer driver program could have a large impact on transportation in Mississippi while imposing minimal costs. One such program in Cumbria County, England has been particularly successful. The county maintains a transportation system that relies on many volunteers but is supported financially by the local government. First, volunteer transportation coordinators organize and recruit drivers.[166] When passengers need a ride, they call the transportation coordinator, who finds a willing driver in the region.[167] The passengers are charged a low fixed price per trip, which they pay to the driver.[168] The

[158] *Telepsychiatry in the Delta*, Delta Health Alliance (Nov. 5, 2011), http://www.deltahealthalliance.org/project/telepsychiatry-in-the-delta/.
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] Mississippi Dep't. of Health, FY 2010 State Plan Implementation Report.
[163] Jill Wolski Ordonez & Michael Cheng, *Mental Health Meets New Media: A Powerful New Portal for Increased Access to Mental Health Services, Service Delivery for Vulnerable Populations* (Steven A. Estrine, Robert T. Hettenbach, Heidi Arthur, Maria Messina, eds.) 375, 382 (2011).
[164] *Internet Use in the United States: October 2009, Table 3: Reported Internet Usage for Individuals 3 Years and Older, by State: 2009*, U.S. Census Bureau, http://www.census.gov/hhes/computer/publications/2009.html.
[165] *GATRA Dial-a-Ride Service*, Greater Attleboro-Taunton Regional Transit Authority, (May 11, 2012), http://www.gatra.org/wp-content/uploads/DAR-1.pdf.
[166] *Voluntary Social Car Scheme*, Cumbria County Council (April 2012), http://www.cumbria.gov.uk/eLibrary/Content/Internet/544/6320/6324/4063994218.pdf.
[167] *Id.*

county pays the driver any difference in the fuel cost and the price paid.[169] It also insures the drivers.[170] Cumbria County also runs a similar program with county-owned buses.[171] The county maintains the buses, but they are driven by trained volunteer drivers.[172]

An important consideration for this type of program is fuel costs, which can be substantial, especially in rural areas. Missed appointments may be especially burdensome with respect to fuel costs. Thus, it may be in any transportation program's best interest to keep track of people who do not keep their appointments and either require them to confirm each appointment, suspend service to them for a time, or institute some other sanction.[173] Free clinics typically address this type of issue by requiring a sliding co-pay. Making patients pay a small co-pay for transportation services once an appointment is made can help deter missed appointments.

Expand the use of telehealth throughout the state

Telehealth can greatly enhance access to mental health services where geographic barriers are an issue because it allows patients to connect to providers without having to travel to such providers. As noted above, services are not provided consistently across the state, creating a situation in which a robust telehealth system could have a huge impact on patients' access to services.

The federal government provides grants to states to encourage telemedicine, including grants to help states reduce regulatory barriers (licensing is a particular problem for doctors serving patients virtually across state lines), improve healthcare services, and coordinate cost-effective programs.[174] These grants provide opportunities to Mississippi to improve its current system of telehealth.

Train practitioners and consumers on how to use telehealth programs

Mississippi could also strengthen its telehealth programs by training practitioners and consumers on how to use such systems. Since primary care physicians are usually the first to spot mental health problems, especially in rural areas, they must be familiar with telehealth so that they can refer patients to specialists who use the technology.[175] Practitioners should be trained before attempting to use telemedicine.[176] For example, patients are more likely to misread doctor's looking away as a sign of distraction if the doctor is on camera rather than in the room with them, since the patient cannot see what the doctor is looking at.[177]

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[168] *Id.*
[169] *Id.*
[170] *Id.*
[171] *Cumbria Community Transport,* Cumbria County Council, http://www.cumbriact.org.uk/ (last visited Mar. 20, 2012).
[172] *Id.*
[173] *Transit Providers and Brokers,* Cmty. Transp. Ass'n (Mach. 30, 2012), http://web1.ctaa.org/webmodules/webarticles/anmviewer.asp?a=752&z=5.
[174] *Telehealth,* Health Resources and Services Administration (Mar. 30, 2012), http://www.hrsa.gov/ruralhealth/about/telehealth/.
[175] Polaha, *supra* note 138.
[176] Amy Novotny, *A New Emphasis on Telehealth*, 42 Monitor on Psychology 40 (2011), *available at* http://www.apa.org/monitor/2011/06/telehealth.aspx.
[177] *Id.*

IV. Children & Mental Health

Mississippi has a disproportionately large percentage of children with mental health problems compared to other states, highlighting a large need for services among Mississippi's children.[178] This section will describe the children's mental health services currently provided in Mississippi, including institutions, community-based services and school-based services, and identify barriers to successful service provision. It will also offer recommendations for increasing children's access to mental health services, based largely on interviews with local service providers and a comprehensive review of relevant literature.

A. Institutionalization

Institutional Services Provided

Two of the five Mississippi DMH state psychiatric hospitals treat children and adolescents. The state also has a specialized treatment facility that serves only minors. These institutions are clustered in the southeast portion of the state.

The East Mississippi State Hospital in Meridian serves adolescent males, and the Mississippi State Hospital in Whitfield serves male and female minors of all ages.[179] In addition to the state hospitals, the Mississippi DMH funds the Specialized Treatment Facility in Gulfport, a residential treatment center for youth with mental health issues and resulting behavioral difficulties.[180] While it is common for states to concentrate services of this type into a small number of sites, Meridian and Whitfield are located relatively near each other, thereby reducing access for many children in the state. In addition, community mental health providers have observed that the programs seem underfunded and that they generally have prohibitively long wait-lists, which often lead to children being placed in programs even further from their homes due to limited openings.[181]

Mississippi's Reliance on Institutions

Federal law requires states that receive Medicaid funds to fully implement the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.[182] It also probibits any program that receives federal aid from discriminating against an individual by reason of a handicap,[183] and requires public entities to administer services, programs, and activities in the most integrated setting appropriate to

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[178] Roland Sturm, JS Ringel & T. Andreyeva, *Geographic disparities in children's mental health care*, 112 Pediatrics 308 (2003).
[179] *DMH Facilities*, Miss. Dept. of Mental Health Facilities (November 5, 2011), http://www.dmh.state.ms.us/facilities.htm.
[180] *Resident Care,* Specialized Treatment Facility (November 5, 2011), http://www.stf.state.ms.us/ResidentCare.htm.
[181] Telephone interview with Ellen Reddy, Executive Director and Community Organizer, Nollie Jenkins Family Center, Inc. (March 16, 2012); Telephone interview with Linda West, Executive Director, Mississippi Families for Kids (March 18, 2012); and Telephone interview with Patrice Jenkins, Functional Behavioral Specialist, Jackson Public Schools (March 17, 2012).
[182] EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. 42 U.S.C. § 1396; *EPSDT Overview,* Health Resources and Services Administration (May 30, 2012), http://mchb.hrsa.gov/epsdt/overview.html.
[183] 29 U.S.C. § 794.

meet the needs of qualified individuals with disabilities.[184] Finally states must identify, locate, and evaluate all children with disabilities, so that qualifying children can receive appropriate services in their local schools, including mental health services for children with emotional disturbances.[185]

In March 2010, the Southern Poverty Law Center (SPLC) initiated a federal lawsuit against the state of Mississippi alleging that the state's mental health system knowingly fails to provide children with intensive mental health services in home- or community-based settings, which "denies children medically necessary services and results in needless institutionalization."[186] The lawsuit alleges that the state has failed to provide "medically necessary intensive home- and community-based mental health services when such services are medically necessary to treat or ameliorate [children's] conditions."[187] It also alleges that the state is has failed to administer services in the most integrated setting appropriate to the needs of children with emotional or behavioral disorders and the state has "discriminated against these children by needlessly placing them in institutional settings to receive mental health care."[188] For over a year, the parties have unsuccessfully attempted to resolve the case through mediation; the case is currently pending, awaiting a ruling on a motion to dismiss one of the charges.[189]

The 2011 DOJ investigation into Mississippi's mental health system found that that hundreds of children with disabilities were unnecessarily institutionalized in violation of federal law and that the state's failure to comply with federal requirements result in further exposure "to needless and harmful institutionalization."[190] It further found that "[c]hildren are particularly vulnerable to the deleterious effects of unnecessary institutionalization" due to isolation and lack of exposure to normalizing experiences during such a critical developmental period.[191] The SPLC similarly argues that

> [c]hildren in Mississippi with behavioral and emotional problems face a rigid, facility-based mental health system that both ignores and exacerbates their needs. In order to access intensive mental health services in Mississippi, children must either deteriorate to the point of crisis required for involuntary hospitalization, or submit to unnecessary institutionalization. Both scenarios force children to relinquish their families, communities, and freedom, and endure isolation multiple placements, and severed connections, making even more challenging the task of helping these children overcome their difficulties.[192]

[184] 28 C.F.R. § 35.130(d).
[185] 20 U.S.C. § 1412.
[186] Complaint at 1, *J.B. v. Barbour*, No. 3:10CV153HTW-CRA (So. D. Miss. filed March 10, 2010).
[187] *Id* at 19.
[188] *Id.*
[189] Telephone interview with Vanessa Carroll, Senior Staff Attorney, Mississippi Initiatives, Southern Poverty Law Center (September 4, 2012).
[190] Letter from Thomas E. Perez, Assistant Attorney Gen., Civil Rights Div., U.S. Dep't of Justice, to Haley R. Barbour, Governor, State of Miss., 28 (Dec. 12, 2011).
[191] *Id.*
[192] *J.B. v. Barbour, supra* note 186 at 1.

B. Community Based Services

Community-based services for children are delivered primarily in two formats: office-based and home-based. Such services range in intensity from short-term residential treatment or respite care to outpatient counseling or case management. According to SPLC, "intensive home-and community-based services are typically designed and supervised by a 'child and family team,'" which are typically made up of a child's family, service providers, and others that would be helpful in developing a treatment plan for a child.[193] By their nature, such services are flexible and individualized, aimed at improving functioning in the home, in school, and in the community.[194]

Mississippi law[195] provides for the development, implementation, and oversight of the Mississippi Statewide System of Care, a coordinated network of agencies and providers working together "to make a full range of mental health and other necessary services available as needed by children with mental health problems and their families."[196] Services are to be: (a) child-centered, family focused, family driven and youth guided; (b) community based; and (c) culturally competent and responsive.[197]

The statute also establishes two state level entities intended to promote collaboration across separate state systems: the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC), as well as local mental health planning teams.[198]

Home and Community Based Services Provided

In addition to providing services to adults, regional community mental health centers provide a variety of services for children and youth and are the primary service providers for children and youth with serious mental illnesses or emotional and behavioral health issues. However, these services, which are primarily office-based, are not provided consistently throughout the state.[199] Furthermore, some centers are only open a few days a week,[200] and resources are spread so thin that it can take weeks to even get an appointment.[201] Access to home- and community-based therapies are even more limited. According to SPLC, home- and community-based therapies provided by the regional mental health centers are infrequent and "inadequate to meet the needs of children with significant behavioral or emotional disorders."[202] Mississippi currently offers home- and community-based services to a limited

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[193] *Reinvesting in the Community: A Family Guide to Expanding Home and Community-Based Mental Health Services and Supports,* NAMI (August 28, 2012), http://www.nami.org/Template.cfm?Section=Research_Services_and_Treatment&template=/ContentManagement/ContentDisplay.cfm&ContentID=76200: p. 8; *J.B. v. Barbour, supra* note 186 at 1.
[194] *J.B. v. Barbour, supra* note 186 at 10.
[195] While Mississippi law does frame the state's approach to community-based mental health services for children, as will be demonstrated below, some of the law's requirements do not appear to be met.
[196] Miss. Code Ann. § 43–14–1.
[197] *Id.*
[198] *Id.*
[199] *Children and Youth Mental Health Servs*, Miss. Dept. of Mental Health (November 5, 2011), http://www.dmh.state.ms.us/children_community_services.htm.
[200] *Id.*
[201] *Id.*
[202] *J.B. v. Barbour, supra* note 186 at 13.

number of children in some areas of the state through Mississippi Youth Programs Around the Clock (MYPAC).[203]

MYPAC is a home- and community-based Medicaid waiver program that seeks to provide alternate services to traditional Psychiatric Residential Treatment Facilities (PRTFs), which are non-hospital facilities that have a provider agreement with a State Medicaid Agency to provide inpatient services to Medicaid-eligible individuals under age 21.[204] MYPAC offers an individualized service plan that includes intensive case management, wraparound services,[205] and/or respite services.[206] Families are involved in the planning and implementation of services, and providers are expected to be available to families 24-hours a day.[207] The two statewide providers of MYPAC services are Mississippi Children's Home Services and Youth Villages, and Pine Belt Mental Healthcare Resources (Region 12 CMHC), which serves the transitional age group (18-21) in their nine counties.[208]

The 2009 Assessment and Study of the Mississippi System of Care by the Human Service Collaborative[209] argues that the "MYPAC initiative is demonstrating that community-based, team-based, and family-driven care can effectively address child, youth, and family needs and simultaneously save tax dollars."[210] The state found that MYPAC "is as good or better than the traditional system of institutionalization of the seriously emotionally disturbed children and youth in the state of Mississippi. The regional community mental health centers, which are the primary service providers in most regions of the state, are not certified at this time to provide MYPAC services.[211] SPLC reported that in the fiscal year preceding its March 2010 lawsuit, fewer than 200 Mississippi children received services through MYPAC.[212]

Another statewide effort to increase children's access to mental health services and keep children in the community is the Making a Plan (MAP) initiative. MAP is a mechanism in which a team comprised of community service providers review cases concerning children and youth up to 21 years of age who have a serious emotional disturbance or mental illness and are at risk for an inappropriate placement in an institution due to the lack of access to needed services and supports in the home and community.[213] The primary goal is to link families to available resources in the community in order to help keep children and youth from being placed out-of-home unnecessarily.[214]

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[203] *Id* at 10.
[204] *What is a PRTF,* CMS.gov (August 28, 2012), http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/WhatisaPRTF.pdf.
[205] Wraparound services are seen more as a process rather than services. Wraparound services involve a holistic approach to an individual's needs; a provider works to identify all of an individual's needs and directly helps address these needs or connects the individual to other supports. *What are Wraparound Services?,* Butte County (August 28, 2012), *http://butte.networkofcare.org/mh/library/article.aspx?id=446.*
[206] Miss. Dept. of Mental Health, Division of Children and Youth Services Directory, 13 (2011).
[207] *Id.*
[208] *Id.*
[209] The Human Service Collaborative is a Washington D.C. based policy and consulting group specializing in service delivery systems.
[210] Cliff Davis, Human Service Collaborative, An Assessment and Study of the Mississippi System of Care 5 (2009).
[211] Letter from Thomas E. Perez, *supra* note 194.
[212] *J.B. v. Barbour, supra* note 186 at 10.
[213] Miss. Dept. of Mental Health, Division of Children and Youth Services Directory, 15, (2011).
[214] *Id.*

Home and Community Based Evidence-Based Services Not Provided

Specific examples of evidence-based practices that are not utilized in Mississippi include multi-systemic therapy (MST) and functional family therapy (FFT).[215] Such practices are broadly accepted and have demonstrated success with juvenile offenders and youth with complex mental health needs.[216] Both are strength-based and short-term models of in-home family therapy, aimed at increasing the youth and family's supports within the community.[217] These practices primarily involve working directly with the various systems involved in a child's life, including family, schools, peers, and community.[218] MST tends to focus more on behavioral interventions, while FFT concentrates on improving relationships.[219] Mississippi is one of only 16 states in the US that does not have an MST team, as opposed to other states in the region including Alabama, Louisiana, Georgia, Florida, South Carolina, North Carolina and Virginia.[220] All of these states have at least one FFT team as well.[221]

The 2011 Mississippi DMH Operational Standards articulates a general value of increasing innovation by providing more evidence-based services and supports.[222] However, it does not offer any further mandate or guidelines as to the use of these best practices in children's service provision, other than for individuals diagnosed with Fetal Alcohol Spectrum Disorders (FASD).[223]

One current effort to increase the use of evidence-based practices is Catholic Charities' Trauma Recovery for Youth (TRY) program, which forms and operates learning collaboratives throughout the state to train clinicians in two evidence-based practices: trauma focused cognitive behavioral therapy (TF-CBT) and structured psychotherapy for adolescents responding to chronic stress (SPARCS).[224] The program offers training sessions, monthly case consultation, and organizational readiness efforts to the Regional Community Mental Health Centers with the goal of spreading evidence-based practice throughout the mental health system.[225] The program has taken off in many regions, but due to limited resources, centers in the Delta region have been slower to get involved.[226] Approximately 35-40 clinicians from regions 2, 5, and 6 formed a Delta Collaborative in 2012, but region 1's center is not involved.[227]

Barriers to Effective Home- and Community-Based Service Delivery

The barriers identified in this section were discovered through academic research, one-on-one interviews with providers and other stakeholders in Mississippi's mental health system, and two focus

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[215] *What is MST?,* Multisystemic Therapy (May 20, 2012), www.mstservices.com/index.php/what-is-mst; *About FFT,* Functional Family Therapy (May 20, 2012), www.fftinc.com/about_model.html.
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] *What is MST?,* Multisystemic Therapy (May 20, 2012), www.mstservices.com/index.php/what-is-mst.
[221] *About FFT,* Functional Family Therapy (May 20, 2012), www.fftinc.com/about_model.html.
[222] Miss. Dept. of Mental Health, Operational Standards for Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Community Service Providers (2011).
[223] *Id.*
[224] Telephone interview with Christina Bach, Clinician Trainer, Catholic Charities, Jackson, MS (March 14, 2012).
[225] *Id.*
[226] *Id.*
[227] *Id.*

groups held in Holmes County. The focus groups were administered by professionals from the Southern Institute for Mental Health Advocacy, Research, and Training and involved 7-10 consumers of mental health services from Holmes County being asked a series of questions about their experiences with Mississippi's mental health system.

Lack of service providers with training to implement evidence-based practices

A primary barrier to the effective implementation of evidence-based approaches in the community, especially in the Delta region, is a lack of qualified service providers. Some Mississippi providers reported that they have considered adopting structured evidence-based practices such as MST and FFT, but determined that they lack the staff to implement them effectively,[228] and many interviewed providers were not even familiar with these practices. Joyce Parker, a community organizer in Greenville, the largest town in the Delta region, reported that there are not enough certified service providers to meet the growing needs of the community, which is seeing an increase both in the number of children diagnosed with mental illness and the complexity of the needs.[229]

Inconsistent provision of services across the state

The Regional Community Mental Health Centers, which are the primary service providers in most regions of the state, are not certified at this time to provide MYPAC services, which means these services are not being provided consistently.[230] SPLC reported that in the fiscal year preceding its March 2010 lawsuit, fewer than 200 Mississippi children received services through MYPAC, while close to 2,000 received mental health services in an institutional setting during the same period, with 557 committed to a state hospital, 888 placed in a psychiatric residential treatment facility, 476 in a therapeutic group home, and hundreds more "cycled through emergency rooms and other acute care facilities for crisis care and treatment."[231]

The 2009 Human Service Collaborative also revealed that children and youth in only small "pockets" of the state have access to "the most effective care infrastructure" - MAP teams.[232] Region 2, which includes six counties, has five MAP teams;[233] Region 5, which has four counties, has one team;[234] Region 6 has one MAP team for eight counties;[235] and Region 15 has a MAP team in each of its two counties.[236] Furthermore, the effectiveness of MAP teams appears to vary somewhat by county.[237] Paula Van Evry of Jackson Public Schools says that MAP can be an effective resource but has limitations.[238] Christina Bach

[228] Telephone interview with Barbara Pigott, Director of Social Services, Catholic Charities (2012) and Telephone interview with Paula Van Evry, Director of Safe Schools/Healthy Students, Jackson Public Schools (2012).
[229] Telephone interview with Joyce Parker, Community Organizer, Citizens for a Better Greenville (2012).
[230] Letter from Thomas E. Perez, *supra* note 190.
[231] *J.B. v. Barbour, supra* note 186 at 10.
[232] Davis, *supra* note 210.
[233] Telephone interview with Connie Harris, Clinical Director of Children's Services, Communicare (March 15, 2012).
[234] Telephone interview with Jacqueline Todd, Director of Children's Services, Delta Community Mental Health Services (March 14, 2012).
[235] Telephone interview with Tammy Harrell, Office Manager, Life Help (March 10, 2012).
[236] Telephone interview with Suzanne Lancaster, Children's Services Coordinator, Warren-Yazoo Mental Health Services (March 14. 2012).
[237] Telephone interview with Janice Wilder, Emergency Shelters for Children (March 1, 2012); Telephone interview with Joy Hogge, Executive Director, Mississippi Families as Allies for Children's Mental Health (March 5, 2012).
[238] Telephone interview with Paula Van Evry, *supra* note 228.

of Catholic Charities reported that MAP teams are not implemented consistently in the Delta region.[239] Joyce Parker of Citizens for a Better Greenville in Region 5 and Ellen Reddy of the Nollie Jenkins Family Center in Region 6 said they are aware of the MAP teams in their areas, but believe there is low participation and are not sure how it works.[240] In addition, the team in Region 6 focuses primarily on helping families with financial problems rather than addressing the level of services a child needs.[241] On the other hand, Suzanne Lancaster of Warren-Yazoo Mental Health Services in Region 15 finds the MAP teams to be extremely helpful and hopes funding continues to be available.[242]

Lack of coordination among stakeholders

The Collaborative also found that Mississippi's educational, child welfare, and juvenile justice systems are all seeking to improve behavioral health services for children and youth but that these efforts are disjointed.[243] Furthermore, the Collaborative discovered that:

> [t]he broader public mental health system that surrounds the MAP teams is doing some good work, with some CMHC regions demonstrating significantly more effort and success in working with children and youth than others, but the help offered is not necessarily well-aligned with the needs of those children and youth or with best practices in the field. Service capacity is a substantial issue in the primary treatment system for children and youth with behavioral health needs, especially in the lack of intensive, community based services.[244]

Lack of sustained, quality service provision

Regarding quality of services, SPLC argues that the home- and community-based therapies provided by the Centers are infrequent and "inadequate to meet the needs of children with significant behavioral or emotional disorders."[245] Furthermore, some centers are only open a few days a week,[246] and resources are spread so thin that it can take weeks to even get an appointment.[247] Many children deteriorate upon discharge from instituonal care due to the community system being "weak and fragmented."[248] Parker also said that the paradigm shift has not yet been made to evidence-based wraparound services in the Delta, as has happened in many other areas of the country,[249] and the Holmes county focus group reported that treatment is not tailored to the needs of the individual.[250]

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[239] Telephone interview with Christina Bach, *supra* note 224.
[240] Telephone interview with Ellen Reddy, *supra* note 181; Telephone interview with Joyce Parker, supra note 229.
[241] Telephone interview with Tammy Harrell, *supra* note 235.
[242] Telephone interview with Suzanne Lancaster, *supra* note 236.
[243] Davis, *supra* note 210.
[244] *Id.*
[245] *J.B. v. Barbour, supra* note 186 at 13.
[246] *Id.*
[247] *Id.*
[248] *Id.*
[249] Telephone interview with Joyce Parker, *supra* note 229.
[250] Focus group interview with Holmes County mental health consumers in Holmes County, MS (March 3, 2012).

Poor relationships between providers and parents

Community members discussed a general distrust of mental health centers, reporting that the community center staff lack the training to provide adequate, culturally competent services.[251] Communication between providers and patients or parents is another area of weakness, which leads to lack of understanding about treatment plans and the importance of compliance.[252] The focus group also reported that general disregard for confidentiality, callousness, and lack of respect for the patients are problems with the mental health center.[253] In addition, community members are concerned about the lack of accountability on the part of the agencies,[254] and parents often report feeling like they are "at the mercy of the agencies."[255]

C. Mental Health & Schools

Schools have long been settings for providing services to children with mental health needs, primarily due to the convenience of having access to students and the need to provide counseling to students with behavioral health problems.[256] While there was an increase in hospital and community-based services throughout the 20th century, there is currently a trend in the U.S. toward revitalizing the provision of mental health services within schools.[257] This movement was largely influenced by the passing of the Individuals with Disabilities Education Act (IDEA) in 2004, which requires schools to address the mental health needs of students with emotional disturbances and provides funding to schools.[258] Mississippi's policies and procedures regarding children with disabilities require both the Departments of Education and Mental Health to comply with the IDEA and provides for some funds to be used to assist schools "in providing positive behavioral interventions and supports and mental health services for children with disabilities."[259]

School-Based Services Provided

The types of services provided by schools nationally vary widely by district and school, but generally include some of the following services: mental health and safety assessments; school-wide preventative campaigns and mental health education; peer and family support groups; behavioral intervention; individual, group, and family counseling; psychiatric care; and referrals to outside treatment providers.[260] In Mississippi, the type of services provided in schools also varies greatly by district. In urban and suburban areas, schools often have counselors and social workers provided by the district, and may contract with community mental health centers or private agencies to provide additional

[251] *Id*; Telephone interview with Helen Johnson, Education Coordinator, Southern Echo (2012); Telephone interview with Joyce Parker, *supra* note 229.
[252] Focus group interview with Holmes County mental health consumers, *supra* note 250.
[253] *Id.*
[254] *Id*; Telephone interview with Joyce Parker, *supra* note 229.
[255] Telephone interview with Joyce Parker, *supra* note 229.
[256] Krista Kutash, Albert J. Duchnowski, & Nancy Lynn, School-Based Mental Health: *An Empirical Guide for Decision-Makers, Research and Training Center for Children's Mental Health* (April 2006).
[257] *Id.*
[258] 20 U.S.C. § 1412
[259] Miss. Dept. of Education, Office of Special Education, State Policies Regarding Children with Disabilities under the Individuals with Disabilities Education Act Amendments of 2004.
[260] Kutash et. al, *supra* note 256.

services.[261] However, in the Delta and many other rural areas of the state, school-based services are often provided exclusively by the regional centers.[262]

The task of implementing comprehensive school-based mental health services to children is generally a complex and challenging one for many reasons, with the most common barriers, especially in Mississippi, being insufficient resources and a lack of funding.[263]

Barriers to Effective Service Delivery in Schools

The barriers highlighted in this section were identified by speaking with various stakeholders based in Mississippi, such as mental health providers and school-focused non-profit leaders, and through in-depth online and academic research. While the barriers identified are mostly framed as statewide issues, they are not necessarily applicable to every school and district in the state.

Services are provided inconsistently across schools and districts.

School-based mental health services in Mississippi are funded almost exclusively by grants, which creates problems of inconsistency and inequality among districts and schools.[264] While it is common for decisions regarding the structure of school-based mental health services to be made at a district level,[265] providers in Mississippi have found that, along with limited funding, schools receive inconsistent guidance and support from the state.[266] This lack of state direction or prioritization places the burden of developing, funding, and implementing programming on individual schools, districts, and communities, which leads to wide disparities in access to and quality of services between schools.[267] There are pockets of district or community specific efforts, but programs that do exist are often narrowly and inconsistently implemented.[268] This also contributes to schools and providers feeling disconnected and isolated in their efforts.[269]

This disproportionality is especially apparent with regard to the services available in urban and suburban districts as opposed to rural communities. A provider from Jackson reports more community mobilization efforts toward increasing access to services in urban and suburban areas.[270] For example, organizers in Jackson Public Schools helped the district obtain a federal "systems of care" grant, which allows for the implementation of a variety of programs, such as social and emotional education in curriculum and an increase in the number of social workers and mental health counselors working in schools.[271] Districts and mental health centers in the rural regions may not to have the capacity for

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[261] Telephone interview with Paula Van Evry, *supra* note 228.
[262] Telephone interview with Helen Johnson, *supra* note 251.
[263] Roleffson S. Foster et. al, *School Mental Health Services in the United States, 2002–2003*, Substance Abuse and Mental Health Administration January 2005: 2.
[264] Telephone interview with Joy Hogge, *supra* note 237.
[265] Kutash et. al, *supra* note 256.
Telephone interview with Helen Johnson, *supra* note 256; Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Paula Van Evry, *supra* note 228.
[267] Telephone interview with Paula Van Evry, *supra* note 228.
[268] *Id.*
[269] *Id.*
[270] *Id.*
[271] *Id.*

these types of significant, time-consuming proposals, as they often do not have the personnel or resources to devote to additional projects.[272]

Lack of understanding about what constitutes a mental illness

Another significant barrier in Mississippi, particularly in rural areas, is a lack of understanding within the school system about what constitutes a mental illness.[273] Many providers reported an overall lack of training for school staff in identifying the differences between mental illness, behavioral problems, and learning disabilities and on how to interact with students with mental illnesses.[274] Therefore schools and teachers often confound mental illness with behavioral disorders,[275] which research shows often leads to students leaving for alternative schools, dropping out of school, or being institutionalized or incarcerated.[276] Relatedly, many providers are concerned about the continued use of corporal punishment for misbehavior in school, which is permitted regardless of whether the child has mental illness or a history of abuse; although parent permission is required.[277] Data from 2008 shows that Mississippi was one of 20 states that still permits some level of corporal punishment in schools.[278] Mississippi's 7.5% of total students being hit was the highest in the country, as compared to 4.5% in Alabama, 1.7% in Louisiana, 1.5% in Tennessee, 1.1% in Georgia and Texas, 0.3% in Florida, and 0.2% in North and South Carolina.[279]

Children are often provided with inadequate and ineffective services

Mississippi stakeholders reported problems with inadequate assessments,[280] insufficient focus on suicide and depression as well as conflict resolution,[281] and deficiencies in cultural competencies by providers.[282] In addition, many providers are reported to rely on outdated, "provider knows best" approaches as opposed to practices that have been shown to improve outcomes for patients with particular illnesses. These practices, such as MST and FFT are client-centered and strength-based.[283]

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[272] Telephone interview with Christina Bach, *supra* note 224.
[273] Focus group interview with Holmes County mental health consumers, *supra* note 250; Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Linda West, *supra* note 181.
[274] Focus group interview with Holmes County mental health consumers, *supra* note 250; Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Joyce Parker, *supra* note 229; Telephone interview with Linda West, *supra* note 181.
[275] Focus group interview with Holmes County mental health consumers, *supra* note 250; Telephone interview with Helen Johnson, *supra* note 251; and Telephone interview with Linda West, *supra* note 181.
[276] *See e.g.,* Christopher Boccanfuso & Megan Kuhfeld, *Multiple Responses, Promising Results: Evidence-Based, Nonpunitive Alternatives to Zero Tolerance* (2011); David Osher, George G. Bear, Jeffrey R. Sprague and Walter Doyle, *How Can We Improve School Discipline*, Educational Researcher 2010 39:48, available at http://edr.sagepub.com/content/39/1/48; and Rennie Center, *Act Out, Get Out? Considering the Impact of School Discipline Practices in Massachusetts*, Policy Brief May 2010.
[277] Telephone interview with Janice Wilder, *supra* note 237; Telephone interview with Joy Hogge, *supra* note 237.
[278] *Corporal Punishment in Schools, by State,* InfoPlease (May 28, 12), http://www.infoplease.com/ipa/A0934191.html.
[279] *Id.*
[280] Telephone interview with Helen Johnson, *supra* note 251; Telephone interview with Joyce Parker, *supra* note 229; Telephone interview with Linda West, *supra* note 181.
[281] Telephone interview with Patrice Jenkins, *supra* note 181.
[282] Telephone interview with Helen Johnson, *supra* note 251; Telephone interview with Joyce Parker, *supra* note 229; Telephone interview with Linda West, *supra* note 181.
[283] Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Joyce Parker, *supra* note 229.

These deficiencies can lead to a failure to properly treat a child's illness, which may result in substantial long-term costs for the state in the form of having to address a crisis situation, the child being caught in the school-to-prison pipeline, or the institutionalization of the child.

Lack of collaboration and coordination

Mississippi schools and mental health providers reported a number of issues regarding continuity of care and collaboration, especially in rural regions. Care is often not family driven,[284] and parents often report feeling alienated by the process.[285] In addition to limited communication with parents, many schools do not reliably provide referrals to services outside of the school when appropriate nor do they work to ensure that students are connected to services when referrals are provided.[286] Additionally, coordination of care between the schools, treatment providers, and any involved state agencies is virtually non-existent.[287] Such lack of coordination can lead to sub-optimal care as different actors involved in a child's treatment may not have access to information needed to effectively fulfill their role in the treatment.

D. Recommendations

Reduce institutionalization while increasing access to evidence-based practices

Reducing institutionalization would provide clinical benefits to children in Mississippi, while also cutting costs to the state. Institution-based services generally cost more per client than community-based services.[288]

Mississippi's successful, but geographically limited efforts to implement evidence-based practices can be expanded to reach all of the state's children and youth in need of services by using funds that currently go toward institutionalization. Mental health providers throughout the state should be trained in, and authorized to provide, MYPAC, which the state and DOJ have recognized as a successful tool. MAP teams should also be more consistently offered throughout the state, particularly in rural regions, and also more closely monitored for efficacy. Finally DMH should use its discretionary budget to fund and incentivize the implementation of new evidence-based practices such as MST and FFT because of the proven effectiveness of these approaches. The state legislature could support such an effort by appropriating funds for these specific programs.

Consistently implement wraparound services throughout the state

Mississippi would also benefit from the consistent implementation of wraparound services throughout the state. Wraparound services focus on emphasizing the strengths of a child while simultaneously addressing the needs of the child and family in an individualized

[284] Focus group interview with Holmes County mental health consumers, *supra* note 250; Telephone interview with Helen Johnson, *supra* note 251; Telephone interview with Janice Wilder, *supra* note 237.
[285] Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Patrice Jenkins, *supra* note 181.
[286] Telephone interview with Janice Wilder, *supra* note 237.
[287] *Id.*
[288] *United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities*, *supra* note 3 at 3.

manner.[289] Services are designed to involve everyone who is significantly involved in the child's life in a collaborative effort to develop and implement an individualized, child-centered treatment plan.[290] These services might include art classes for a child with behavioral issues, along with aid to accompany that child to art class.[291] Wraparound services are viewed as extremely effective in addressing the needs of children with mental health needs.[292] Research shows that as opposed to those who are institutionalized, children receiving wraparound services are hospitalized less often, have fewer arrests and stays in detention; sustain their mental health improvements; have less suicidal behavior; and have better school attendance and higher achievement.[293]

Massachusetts offers an example of a state that has developed a consistent system of referral to wraparound services after being sued for failure to effectively provide such services.[294] Every region in the state now has a Community Service Agency that conducts evaluations of children referred to the state's Medicaid system to assess the strengths and needs of a child and her family, in order to determine whether the child has a serious emotional disturbance or other mental health needs, and to make treatment recommendations.[295] Based on these recommendations, the state will provide medically appropriate care from a continuum of services, including wraparound services.[296]

Require mental health professionals and school officials to participate in ongoing training programs addressing cutting-edge children's mental health issues.

Mississippi appears to lack a commitment to ongoing mental health training for mental health providers, schools, and families.[297] This may be hugely detrimental to the state's children with mental health issues. The need for ongoing development is supported by research; "providing training on innovative techniques to staff without adequate follow-up (e.g., coaching and supervision) is not effective and will result in flawed implementation."[298] Thus, the state would likely greatly benefit from an ongoing training program that educates school officials and mental health professionals on cultural competency, emerging technology, and other facets of children's mental health.

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[289] *Id.*
[290] *Id.*
[291] Nancy C. Winters & W. Peter Metz, *The Wraparound Approach in Systems of Care* 140 (2009), *available at* http://www.oregon.gov/oha/amh/wraparound/docs/wraparound-approach-soc.pdf.
[292] *Id.*
[293] *Id.*
[294] *See* Quick Reference on CBHI Mental Health Services for Youth: A guide to Services Implemented Due to the Rosie D. Litigation. February 2, 2010.
[295] *Id.*
[296] *Id.*
[297] Focus group interview with Holmes County mental health consumers, *supra* note 250; Telephone interview with Christina Bach, *supra* note 224; Telephone interview with Ellen Reddy, *supra* note 181; Telephone interview with Joy Hogge, *supra* note 237; Telephone interview with Joyce Parker, *supra* note 229; Telephone interview with Helen Johnson, *supra* note 251; Telephone interview with Linda West, *supra* note 181; and Telephone interview with Patrice Jenkins, *supra* note 181.
[298] Kutash et. al, *supra* note 256.

Increase the amount of mobile crisis services focused on children in rural areas.

Mobile crisis services are a critical area of mental health programming and are not provided in all of the state's mental health regions. The aforementioned Human Service Collaborative system of care assessment study articulated that:

> [c]hildren and adolescents who enter into expensive, intensive, bed-based care do so through cris[es], with few exceptions. The ability to respond to such crises with interveners with knowledge of mental health conditions and treatment increases the ability to keep families intact and minimize out-of-community placements, decreasing the collective care burden on all of the community helping systems … Crisis teams can form across service system boundaries, jointly responding to child safety, community safety, and treatment needs presented by children and adolescents, to cost-effectively [respond to the situation][299]

Provide centralized support for community- and school-based services.

A centralized support body for community and school-based services would be well-positioned to address some of Mississippi's most urgent mental health needs for children by serving to develop and implement innovative children's mental health practices. Such a body could also help devise strategies to streamline and coordinate the efforts of stakeholders across the state. This would be consistent with the Human Service Collaborative's 2009 recommendation to "[e]mpower the [Interagency Coordinating Council for Children and Youth (ICCY)][300] by giving it authority to impact policy and funding decisions across all public service sectors touching children and adolescents."[301] The Collaborative argued that, with the ICCY's help, "[s]tate agencies would make the work of local MAP teams extraordinarily easier by negotiating those types of partnerships at the state level, changing practices within major systems to more strongly support collaborative, team-based work."[302]

Massachusetts offers a successful example of such a centralized support body that Mississippi could emulate. In 2008, Massachusetts passed *An Act Relative to Children's Mental Health*, which included a section requiring the development of an infrastructure across the state to assist schools in creating "safe, supportive, environments" and to increase support and "collaborative services" for students with behavioral and mental health issues.[303] The law required a task force to develop an organizational structure to enable schools and districts to partner with parents, community organizations, and service providers to create supportive school environments.[304] The task force then created the Behavioral Health and Public Schools Framework (the Framework), which is a set of guidelines for addressing behavioral health in schools. It is broken down into six sections:

(1) leadership;

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[299] Davis, *supra* note 210.
[300] The Interagency Coordinating Council for Children and Youth was established by the Mississippi state legislature to develop and implement a "coordinated interagency system of necessary services and care" for children and youth. Miss. Code Ann. § 43–14–1.
[301] Davis, *supra* note 210.
[302] *Id.*
[303] An Act Relative to Children's Mental Health, MA Session Laws, 321(19)(a), (2008).
[304] *Id.*

(2) professional development;
(3) access to resources and services;
(4) academic and non-academic strategies;
(5) policies and protocols; and
(6) collaboration with families.[305]

The Framework also includes provision of support for students at three levels: promotion, prevention, and intervention.[306] Finally the Act required the task force to develop and conduct a statewide assessment based on the Framework in order to "assess the capacity of schools to collaborate with behavioral health services and provide supportive school environments that can improve outcome measures."[307] This type of centralization maintains a level of discretion and freedom of action within districts and schools, but nonetheless provides a source of support and direction that can lead to the more widespread utilization of effective approaches.

Increase the use of school climate programming

While school climate programming is not specifically a mental health intervention, it can be a cost-efficient and rather easily implemented method that research has shown to have an extremely beneficial impact on the behavior, academic achievement, and emotional development of all children.[308] There are several different research-supported programs that target the behavior of at-risk students and seek to improve school climate,[309] and Mississippi could likely benefit from the consistent implementation of any one of these programs. Common elements of these effective programs include:

(1) daily or weekly interactive exercises to help students build social skills and learn to resolve conflict; and
(2) individualized behavioral support through training sessions and behavioral plans that pull in family members.[310]

As of 2011, Positive Behavioral Interventions and Supports (PBIS) had been adopted by more than 13,000 schools nation-wide, making it one of the most widely used positive behavior support endeavors in the nation.[311]

The Mississippi system of care statute states that PBIS is to be implemented statewide in schools.[312] PBIS is "a decision-making framework that guides selection, integration, and implementation of the best evidence-based academic and behavioral practices" in efforts to create a positive and safe school

[305] Final Report of the Massachusetts Behavioral Health and Public Schools Task Force, Appendix A: The Behavioral Health and Public Schools Framework 1-2 (2011) *available at* http://bhps321.org.
[306] *Id.*
[307] An Act Relative to Children's Mental Health, MA Session Laws, 321(19)(c), (2008).
[308] *See* Blum, R.W., McNeely, C.A., & Rinehart, P.M. (2002). *Improving the odds: The untapped power of schools to improve the health of teens*. Minneapolis: University of Minnesota, Center for Adolescent Health and Development; *see also* Osterman, K.F., *Students' need for belonging in the school community*, 70 Review of Educational Research 323 (2000).
[309] Christopher Boccanfuso & Megan Kuhfeld, *Multiple Responses, Promising Results: Evidence-Based, Nonpunitive Alternatives to Zero Tolerance* 4 (2011).
[310] *Id.*
[311] *Id.*
[312] Miss. Code Ann. § 43–14–1.

climate.[313] Although mandated by law, the program is not being implemented in many schools throughout the state, likely because there is no enforcement mechanism.[314] By implementing an enforcement mechanism or way to incentivize schools to adopt PBIS, Mississippi can immediately increase the support its schools have for children with behavioral needs.

An example of a school successfully utilizing PBIS is the MacArthur Middle School in Fort Meade, Maryland. MacArthur has a code of student conduct that emphasizes respect for others and establishes behavioral expectations for the entire school.[315] Teachers also use school data to "develop social skill lessons that set forth expectations for personal interaction."[316] To strengthen the skills and norms being taught, students are rewarded for positive behavior with "tickets" that can be used to purchase items or entrance to school events and struggling students are paired up with adult mentors. Each year, the faculty is evaluated on their behavioral approaches in order to ensure that such approaches are effective. This program has been cited as a "Best Practice" by the Johns Hopkins Bloomberg School of Public Health.[317]

Increase the accessibility of information regarding children's mental health services

It can often be difficult for parents and other stakeholders to identify what type of mental health services are available for children in their area. For example, Region 3's community mental health center has no listed website and Region 13's center's website states that it provides "a full range of services for children with adjustment, behavioral, and learning problems," but does not specify which services are available.[318] Although other professionals and community members may be aware of locally provided services, it is important for parents to have easy access to this information. Among other reasons, parents may not with to discuss their child's mental health with others in the community. Valuable services may be underutilized simply because of an information gap between regional centers and consumers. As a result, regional centers should clearly describe the services they provide to children on their websites and prioritize outreach efforts to parents and other stakeholders.

[313] *What is PBIS?*, PBIS (May 29, 2012), http://www.pbis.org/school/what_is_swpbs.aspx.
[314] Telephone interview with Helen Johnson, *supra* note 260; Telephone interview with Paula Van Evry, *supra* note 233.
[315] *Best Practices: Building Blocks for Enhancing School Environment*, John Hopkins Bloomberg School of Public Health (Jan. 4, 2012), http://www.jhsph.edu/bin /o/c/Best_Practices_monograph.pdf.
[316] *Id.*
[317] *Id*. at 15.
[318] *Services,* Gulf Coast Mental Health Center (Nov. 5, 2011), http://www.gcmhc.com/services.html.

V. Criminal Justice System and Mental Health

This section of the report will discuss the current state of mental health in Mississippi's criminal justice system and offer suggestions for improving it. As a result of cuts in the state's mental health budget, the burden on the criminal justice system to house the mentally ill has increased. Approximately 5,200 adults with mental illnesses were incarcerated in Mississippi prisons in 2008.[319] A 2010 study estimated that the ratio of persons suffering from SMI who are incarcerated versus being treated in a state hospital is 1.8 to 1.[320]

To address this high ratio of incarcerated mentally ill to those in treatment (albeit institutionalized treatment), the criminal justice system can implement intervention systems at each stage of the process: law enforcement response, pre-trial processes, trial and sentencing, and release.

A. Response to a Disturbance or Crime

In order to help law enforcement authorities properly address disturbances involving persons with mental health issues, Mississippi has authorized law enforcement agencies and community mental health centers to establish crisis intervention teams.[321] Crisis intervention teams are groups of law enforcement officers who have undergone training that better prepares them to address police situations involving individuals with a mental illness.[322] This concept was first adopted by the Memphis Police Department in 1988 and has shown to effectively reduce the chance of violence on police calls, which has led several other jurisdictions to adopt the approach.[323]

Four crisis intervention teams exist in Mississippi.[324] Of those teams, three operate under city police departments and one, in Hinds, operates on a county level.[325] The Hinds County team was established in 2010, but not funded.[326] Without robust support for such programs, law enforcement authorities cannot adequately address situations involving persons suffering from mental illnesses. Whereas members of crisis intervention teams receive 40 hours of instruction on how to approach the mentally ill, the Mississippi Law Enforcement Officers Training Academy only provides four hours of such instruction to new officers (i.e., those not enrolled in crisis intervention teams).[327]

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[319] National Alliance on Mental Health (February 15, 2012), http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93503.
[320] E. Fuller Torrey, *More Mentally Ill Persons are In Jails and Prisons than Hospitals: A Survey of the States*, Treatment Advocacy Center (June 12, 2012), http://treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.
[321] Miss. Code **§** 42-21-133.
[322] *Crisis Intervention Team*, Portland Police Bureau (June 11, 2012), http://www.portlandonline.com/police/index.cfm?c=30680.
[323] M.J. Stephy, *De-Criminalizing Mental Illness*. Time Magazine, Aug. 2005; M.J. Stephy, *De-Criminalizing Mental Illness*. Time Magazine, Aug. 2005; Coordinated by Council of State Governments. *Criminal Justice/Mental Health Consensus Project* (June 2002). They are trained to "speak softly, rather than shouting commands, repeating phrases, holding hands palms-up instead of holding a gun or badge, and wearing plainclothes instead of uniforms
[324] The University of Memphis CIT Center National Directory (2012), *available at* http://cit.memphis.edu/.
[325] *Id.*
[326] *New Law Permits Compassion in Arrests*, The Commercial Appeal (June 12, 2012), http://www.commercialappeal.com/news/2010/oct/16/law-permits-compassion-in-arrests/?print=1.
[327] *Id.*

B. Pre-trial, Trial, and Sentencing

In 2010, Mississippi adopted the state's first behavioral court, also known as a "mental health court," in Hattiesburg, Mississippi. The court targets the "special needs of misdemeanor offenders suffering with mental [illness],"[328] and appears to be the only mechanism in the state's pre-trial and trial processes that specifically consider and address mental illness. Pine Belt Mental Health experts examine the offender and, if accepted into the program, assist the participant through completion.[329] If the participant completes the program, her charges are dismissed from the Municipal Court.[330]

Mental health courts are growing in popularity – over 150 now exist nationwide.[331] Such courts have been found to be more cost-effective than traditional forms of prosecution and provide better rehabilitation. Mental health courts reduce recidivism and are cheaper than sending people to prison.[332] For example, in Ohio, it costs $30/day to have a person participate in its mental health court program, while it costs $60/day to put them in prison.[333]

Other than Mississippi's sole mental health court, there appear to be few mechanisms in the state's pre-trial and trial processes that specifically consider and address mental illness. The state offers diversion programs if a defendant meets several qualifications including determination "that the needs of the offender and the state can be better met outside the traditional criminal justice process."[334] Those suffering from mental illness may be more likely to qualify for such programs because addressing the likely impetus of their illegal behavior may be more effectively done through a treatment program rather than prison. However, since mental illness is not specifically cited under these general qualification,[335] these programs cannot be used to divert all offenders with mental illness systematically.

C. Incarceration and Release

Mississippi has seven major correctional facilities. Three of these facilities – Mississippi State Penitentiary, Central Mississippi Correctional Facility, and South Mississippi Correctional Institution – are state-run.The remaining four – East Mississippi Correctional Facility, Walnut Grove Youth Correctional Facility, Marshall County Correctional Facility, and Wilkinson County Correctional Facility – are private facilities.[336] Mississippi has contracted with Wexford Health Sources to provide on-site mental health services at the state-run facilities, while each private facility contracts with its own medical provider.[337]

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[328] Associated Press, MSNBC (March 10, 2012), http://www.msnbc.msn.com/id/37062894/ns/health-mental_health/t/hattiesburg-mental-health-court-be-st-state/#.T4CcGOxSQg0.
[329] A community-based mental health provider in Mississippi.
[330] *Id.*
[331] *Fact Sheet on Mental Health,* Florida Mental Health Institute (June 10, 2012), http://www.floridatac.org/files/document/Orlando%20Fact%20Sheet%20on%20Mental%20Health%20Courts.pdf.
[332] Dale E. McNeil and Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence,* American Journal of Psychiatry, Vol. 164, No. 9 (September 2007).
[333] *States Try out Courts Tailored for Mentally Ill,* National Public Radio (June 9, 2012), http://www.npr.org/templates/story/story.php?storyId=5685265.
[334] Miss. Code **§** 99-15-109.
[335] *See id.*
[336] *MDOC Healthcare Services,* Mississippi Department of Corrections (June 12, 2012), http://www.mdoc.state.ms.us/medical_services.htm.
[337] *Id.*

Wexford Health Sources provides mental health screening/assessment to all inmates. Those receiving a positive screening receive further evaluation and needed services. Services offered include 24/7 crisis intervention, suicide prevention, individual psychotherapy, group therapy, and pharmacotherapy. However, it is unclear how consistently these services are provided at Mississippi's public institutions.

A 2003 report by Human Rights Watch found that Mississippi State Correctional facility was extremely understaffed with respect to mental health professionals, leading to inconsistent and suboptimal service delivery.[338] The study states:[339]

> In Mississippi's enormous Parchman prison (officially known as the Mississippi State Penitentiary), one part-time psychiatrist and two university psychiatrists put in a total of forty hours per week of psychiatric coverage, much of it tele-medicine-based. The prison also has five psych-assistants and four case managers. Its one psychologist position was, as of May 2003, vacant. This paltry staff is responsible for the mental health needs of a prison population of well over five thousand prisoners spread across buildings and land that take up a massive eighteen thousand acres. The university psychiatrists never visit the prisoners in person, and have sessions via teleconferencing about once every three months, for about ten minutes. Other than medications, few prisoners have any access to counseling or therapy, and if they do it is usually for only a few minutes a month.

The state's other public-run prisons also appear to be understaffed. The study continues:[340]

> At Central Mississippi Penitentiary, 2,500 prisoners are serviced by thirty-two hours a week of psychiatric coverage, one non-Ph.D.-level psychologist and ten lower level case managers, psychiatric evaluators and psych assistants. Meanwhile, the Southern Mississippi Penitentiary currently has no psychiatric coverage at all. If prisoners are deemed to need anything beyond medication, they have to be bussed to the Central Mississippi facility.

According to an article published by the American Civil Liberties Union in April 2012, Wexford provides abysmal care in several Mississippi prisons.[341]

East Mississippi Correctional Facility, one of the state's private prisons, was designed for inmates with special needs and therefore houses many adults who are diagnosed as mentally ill.[342] At this correctional facility, there is a Behavior Enhancement Program, Psychoactive Services, a Therapeutic Community Program, Specialized Group Therapy, Specialized Individual Counseling, and Psychiatric Review every 90 days.[343] Other private prisons appear to provide far fewer mental health services.

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[338] *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness,* Human Rights Watch (June 12, 2012), http://www.hrw.org/sites/default/files/reports/usa1003.pdf: p. 113.
[339] *Id.*
[340] *Id.*
[341] *Private Prisons are the Problem, Not the Solution*, ACLU (September 5, 2012), http://www.aclu.org/blog/prisoners-rights-criminal-law-reform/private-prisons-are-problem-not-solution.
[342] *Mental Health Care in Prisons* (2001), National Institute of Corrections (May 30, 2012), http://static.nicic.gov/Library/016724.pdf.
[343] *Private Prisons,* Mississippi Department of Corrections (June 12, 2012), http://www.mdoc.state.ms.us/Five%20Private%20Prisons.htm.

While Mississippi's Department of Corrections website states that all of the above mentioned services are provided at East Mississippi Correctional Facility, it does not list any such services as being provided at the Marshall County Correctional Facility or the Walnut Grove Youth Correctional Facility and only lists a therapeutic community as being provided at the Wilkinson County Correctional Facility.[344]

D. Recommendations

Stage 1: Response to a Disturbance or Crime

Provide dispatchers with tools to identify when a mentally ill person may be on the scene

To ensure law enforcement officials are prepared to deal with a mentally ill individual when they arrive on scene, dispatchers should be provided "with tools to determine whether mental illness may be a factor in a call for service."[345] Training and having a set of standardized questions – created with the help of mental health providers – can help dispatchers identify when a mentally ill person may be involved in the situation.[346]

Provide funding for crisis intervention teams

Despite legislation allowing crisis intervention teams in Mississippi, a lack of funding appears to have prevented the development of such teams. Given the proven effectiveness of crisis intervention teams, investment in them could help the state reduce costs associated with violence during police confrontations with mentally ill individuals while simultaneously ensuring such individuals' conditions are taken into account upon arrest.

Hire mental health professionals to respond to calls

Hiring mental health workers to respond to emergency calls with law enforcement officials has also proven to be an effective way to respond to situations involving mentally ill individuals. These workers may or may not be members of the police department, and can ride alongside officers or respond when called to a scene by an officer.[347] The Birmingham Police Department, for example, hires social workers to "respond directly to an incident location when requested by an officer."[348] Called Community Service Officers (CSO), these social workers "provide services to mentally ill, indigent and challenged individuals."[349] They neither carry weapons nor have the ability to make arrests.[350] According to a survey, over a third of the Birmingham Police Officers thought the CSO program met the needs of people with mental illnesses and half thought it helped keep mentally ill people out of jail and made the

[344] *Id.*
[345] *Criminal Justice/Mental Health Consensus Project Overview*, Consensus Project (August 28, 2012), http://consensusproject.org/downloads/overview.pdf: p. 6.
[346] *Id.*
[347] *Id.*
[348] *Id.*
[349] *Field Operations Bureau,* Birmingham Police Department (May 29, 2012), http://www.informationbirmingham.com/police/field-operations.html.
[350] *Los Angeles Police Department Consent Decree Mental Illness Project,* LAPD (June 13, 2012), http://www.lapdonline.org/assets/pdf/consent_decree_mental_ill_append.pdf.

community safer.[351] The Long Beach (CA) Police Department, the San Diego (CA) Sheriff's Office, and the Anne Arundel County (MD) Police Department have all adopted similar programs.[352]

Stage 2: Pre-trial, Trial, and Sentencing

Ensure defense attorneys are prepared to advocate for clients with mental health issues

To make sure mentally ill people who are arrested are provided with adequate council, it is important that defense attorneys are aware of mental health resources in the community.[353] It is also important that they are provided with the defendant's mental health status (if appropriate) as soon as possible. For example, Georgia allows defense attorneys access to state mental health records, with client consent .[354] Yet attorneys cannot obtain informed consent without ensuring the client is competent to give consent. A court must ensure there are procedures to protect the confidentiality of mental health records if attorneys have access to such records before informed consent can be secured. In Hamilton County, Ohio, as soon as it is determined that a defendant has a mental illness, a defense attorney is assigned and the case is put in a special afternoon calendar.[355] By taking these steps, defense attorneys are better able to balance the interest of reducing their clients' chances of being incarcerated while also ensuring that their rights are respected.[356]

Create More Mental Health/Behavioral Health Courts

As mentioned earlier, Hattiesburg is the only city in Mississippi with a behavioral health court. Mental and behavioral health courts reduce recidivism rates for persons with mental illnesses.[357] Thus, increasing the number of behavioral health courts in Mississippi could help the state reduce the number of persons suffering from mental illness that are incarcerated, saving taxpayer dollars and improving health outcomes. Mississippi should look to other states with a statewide system of mental health courts (e.g., New York, Ohio), for ideas on how to create an effective system for the whole state.

Stage 3: Incarceration and Release

Increase the number of mental health professionals working in state prisons

By increasing the number of mental health professionals working in state prisons, Mississippi could greatly enhance the care received by mentally ill inmates. In turn, the state will likely save money as such individuals will be more likely to fully rehabilitate, allowing them to exit prison at a faster rate and lowering their chances of recidivism.

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[351] *Id.*
[352] *Criminal Justice/Mental Health Consensus Project, supra* note 345.
[353] *Id.*
[354] *Id.*
[355] *Id.*
[356] *See id.*
[357] Dale E. McNeil and Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence,* American Journal of Psychiatry, Vol. 164, No. 9 (September 2007).

Require a pre-sentence investigation for all mentally ill individuals

According to the American Bar Association, a court should order a pre-sentence investigation report (PSI) when it lacks sufficient information to perform its sentencing responsibilities.[358] Judges are not experts on mental health and are not in the best position to decide the sentence of a mentally ill person without the assistance of a mental health professional. Therefore, a PSI report should be prepared anytime a mentally ill person is sentenced to ensure sentencing is appropriate for the individual (e.g., Washington state requires this prior to the sentencing of any individual with mental illness).[359]

Ensure continuance of treatment when an inmate with a mental illness is transferred

If an inmate is deemed to be mentally unstable, it is important to "develop an individualized treatment, housing, and programming plan, and ensure that this information follows the inmate whenever she is transferred."[360] In Mississippi, when a prisoner with a mental illness is transferred, they may go a few days without getting treatment, which can result in serious decline in health.[361] Moreover, when it is decided that a prisoner needs to be transferred or to have psychiatric treatment, "it can take several weeks for a prisoner to be removed to an inpatient unit."[362] To ensure that treatment is uninterrupted, Wisconsin created a Health Transfer Summary that must be reviewed and filled out by a health care provider.[363] If treatment is interrupted, there is a risk of prisoners regressing behaviorally, mentally, or emotionally. Arizona has a law that a prisoner's medical records must be transferred prior to or at the same time as the prisoner's transfer.[364] By taking steps such as these, Mississippi can improve its ability to treat prisoners with mental illness without interruption.

Help offenders with mental illness meet the conditions of their parole or probation
Studies show that offenders with mental illness recidivate at a higher rate than those without mental illness.[365] The recidivism rate for mentally ill people can be reduced if services are offered to help them meet parole or probation requirements. To do this, it is important to know the needs of the individual and which resources within the community can help meet those needs.[366] The resources may be provided by a variety of organizations, ranging from state mental health hospitals to churches. The Adult Probation Department in Cook County, Illinois has probation officers with backgrounds in mental health to ensure that they are able to identify and meet the needs of mentally ill people.[367] The county also has a three-step probation program that a mentally ill person has to complete before they are put on the standard probation program.[368] The phases are designed to incentivize compliance by being

[358] *Criminal Justice/Mental Health Consensus Project, supra* note 345.
[359] *Id.*
[360] *Id*.
[361] *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness,* Human Rights Watch (June 12, 2012), http://www.hrw.org/sites/default/files/reports/usa1003.pdf.
[362] *Id.*
[363] *Wisconsin Health Transfer Summary,* http://www.wi-doc.com/PDF_Files/2077%20Health%20Transfer%20Summary%201-09.pdf.
[364] *Criminal Justice/Mental Health Consensus Project, supra* note 345.
[365] *Id.*
[366] *Id.*
[367] *Id.*
[368] *Id.*

highly restrictive at first and becoming less restrictive as clients meet certain compliance goals, thereby helping persons with mental illness prepare for the demands of regular probation.[369]

VI. Stigma

A. Overview of Stigma and Its Effects

Stigma is "a cluster of negative attitudes" associated with mental illness.[370] Stigma involves not only misunderstanding and judgment, but also disrespect, discrimination, and alienation of those suffering from mental illness.[371] People with mental illnesses are often stigmatized due to the misperception that they have weak character and/or are prone to violence.[372] This section will briefly discuss how stigmatization affects Mississippians suffering from mental illness and will outline current efforts to address stigma in the state. This section also puts forth recommendations for addressing the issues raised.

Stigma may cause family members, friends, and community members to fear and avoid those suffering from mental illnesses.[373] This separation and loss of relationships can be extremely harmful as it may cause some people with mental health conditions to avoid treatment and it can have a negative effect on emotional stability.[374] In rural communities, a fear of stigma is particularly likely to deter people from seeking treatment because there is a greater likelihood that the entire community will be aware that an individual is mentally ill.

B. Efforts to Address Stigma in Mississippi

Mississippi's DMH is currently working to raise awareness of and combat stigma associated with mental illness through its "Think Again" campaign. The campaign "is designed to increase understanding of mental health among young adults through educational materials, presentations, and other avenues."[375] On the campaign's website, people can access educational flyers as well as request presentations on different mental health issues. The campaign also creates public service announcements about mental health that appear in Mississippi newspapers.

DMH also partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to create the "What a Difference a Friend Makes" campaign, designed specifically to combat stigma. This program differs from "Think Again" in that it is more focused on large-scale public education about

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[369] *Id.* at 122.
[370] P. Callens, *Stigma: Helping to Create New Beginnings*, North Mississippi State Hospital (Nov. 2, 2011), http://www.nmsh.state.ms.us/Stigma.htm.
[371] *Id.*
[372] *Id.*
[373] Callens, *supra* note 370.
[374] M. Tartakovsky, *When Mental Stigma Turns Inward*, Psych Central (Nov. 2, 2011), http://psychcentral.com/blog/archives/2011/05/26/when-mental-illness-stigma-turns-inward.
[375] *DMH Launches Statewide Think Again Campaign*, Mississippi DMH (May 19, 2012), http://www.dmh.state.ms.us/pdf/DMHLaunchesThinkAgainCampaign.pdf.

mental health. For example, in 2007, the goal of the program was to reach 300,000 people through print materials, speaking engagements, and media coverage.[376]

C. Recommendations

Expand the "Think Again" Campaign

The "Think Again" campaign is a program that has the capacity to help the state make great strides with respect to mental health awareness and stigma. By expanding the scope of the program to include strategies proven successful by other states, Mississippi can realize the full potential of the "Think Again" campaign. In addition to targeting young adults, the campaign could also focus on mental health professionals. For example, the Mental Health Empowerment Project in Illinois connects mental health providers to educational and networking opportunities.[377] "Think Again" could take a similar approach and offer trainings to providers that combat awareness and stigma. The campaign could also adopt strategies from Canada's successful "My Mental Health" campaign, such as targeting community organizations.[378]

Research Cultural Competency Efforts

Many practitioners and stakeholders expressed a need for greater cultural competency trainings to combat stigma and sensitize health professionals to the needs of local communities. In an effort to decrease stigma, professionals and practitioners need to be aware of the unique conditions of the areas they work in and must develop strategies for treating patients that account for such conditions. For instance, in response to the conditions of rural areas, researchers have supported specific ethical guidelines to deal with confidentiality issues, long distance patients, and interpersonal relationships outside of the patient-physician relationship.[379] Advocacy groups could research current cultural competency efforts in Mississippi to identify potential areas of improvement.

Increase integrated health services in rural communities

Integrating health services involves providing mental health care and other forms of treatment at a single location as well as having providers at such locations that have the ability to address multiple types of health issues. Integrated health services can mitigate the deterrent effect of stigma in rural communities by offering greater privacy to patients.[380] The Laurel Health System in Wellsboro, Pennsylvania has adopted an integrated services approach partly to combat the effects of stigma; it operates a general hospital and outpatient mental health center in the same building.[381] Adopting such

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[376] *What a Difference a Friend Makes – Mississippi,* SAMHSA (May 19, 2012), http://stopstigma.samhsa.gov/campaigns/Program_Details.aspx?ID=165.
[377] *Mental Health Empowerment Project*, Mental Health America of Illinois (May 19, 2012), http://www.mhai.org/?page_id=194.
[378] My Mental Health (May 19, 2012), http://www.mymentalhealth.ca/Home/tabid/829/Default.aspx; *My Mental Health Campaign Outcomes,* My Mental Health (May 19, 2012), http://www.mymentalhealth.ca/LinkClick.aspx?fileticket=CXlmKqo3jP0%3D&tabid=1233.
[379] J. Werth Jr., S. Hastings, & R. Riding-Malo, *Ethical challenges of practicing in rural areas*, 66 *Journal Of Clinical Psychology* 537 (2010).
[380] Donna Bird, Noel Genova, David Hartley, David Lambert, The National Rural Health Association, *Integrating Primary Care and Mental Health Services: Current Practices in Rural Areas,* http://www.ncfh.org/pdfs/5042.pdf.
[381] *Id.*

a strategy or other models of integrated health services could increase rural Mississippians willingness to seek out and receive mental health care, resulting in better health outcomes.