MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMMUNITY MENTAL HEALTH SERVICES FY 2018 – 2019 STATE PLAN

Supporting a Better Tomorrow...Today

DMH

Mississippi Department of Mental Health

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 809399926

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Mississppi Department of Mental Health

Organizational Unit Bureau of Communtiy Services

Mailing Address 239 North Lamar Street, 1101 Robert E. Lee Building

City Jackson

Zip Code 39201

II. Contact Person for the Grantee of the Block Grant

First Name Diana

Last Name Mikula

Agency Name Mississppi Department of Mental Health

Mailing Address 239 North Lamar Street, 1101 Robert E. Lee Building

City Jackson

Zip Code 39201

Telephone (601) 359-1288

Fax 601-359-6295

Email Address diana.mikula@dmh.ms.gov

III. Third Party Administrator of Mental Health Services

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 8/29/2017 2:31:33 PM

Revision Date 3/15/2018 12:11:27 PM

VI. Contact Person Responsible for Application Submission

First Name Jake

Last Name Hutchins

Telephone (601) 359-1288

Fax (601) 359-6295

Email Address jake.hutchins@dmh.ms.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: Executive Director Date Signed: 08/16/17

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached

PHIL BRYANT
GOVERNOR

September 1, 2015

Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

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

If you have any questions, please contact Ms. Mikula or Jake Hutchins, Director of the Bureau of Community Services, at (601) 359-1288 or by email at jake.hutchins@dmh.state.ms.us.

Sincerely,

Phil Bryant
GOVERNOR

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Title

Organization

Signature: Dana S Mitchell Date: 8/28/17

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Overview of the State Mental Health System

The State Public Mental Health Service System is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

The Service Delivery System is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

The Board of Mental Health governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

The Department of Mental Health Central Office is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of bureaus.

The Bureau of Administration works in concert with all bureaus to administer and support development and administration of mental health services in the state. Information Systems is also a part of the bureau.

The Bureau of Community Mental Health Services is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services for adults with serious mental illness and children with serious emotional disturbance. This includes crisis response as well as access to care and training to assist with the care and treatment of persons with Alzheimer's disease/other dementia.

The Bureau of Alcohol and Drug Services has the responsibility of administering fiscal resources (state and federal) to the public system of prevention, treatment, and recovery supports for persons with substance use disorders. The overall goal of the state's substance use disorder service system is to provide quality care within a continuum of accessible community-based services including: prevention, outpatient, withdrawal management, intensive outpatient, primary and transitional residential treatment, opioid treatment services and recovery support.

The Bureau of Mental Health is responsible for the planning, development and supervision of an array of services for individuals served at the state-operated behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for people in the state with intellectual and

developmental disabilities. The service delivery system is comprised of the ID/DD Waiver program, the IDD Community Support Program, and five state- operated comprehensive IDD programs located in communities throughout the state. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by community mental health centers and other community service providers.

The Bureau of Outreach, Planning and Development is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also oversees internal and external communications, public awareness campaigns, suicide prevention efforts, government affairs, and developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH.

The Bureau of Human Resources is responsible for the employment and personnel matters of each of the Bureaus. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau is responsible for workforce development which is inclusive of managing the on-line learning system, organizing training opportunities for employees and assisting with the documentation of employee training credits. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

Functions of the Mississippi Department of Mental Health

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

State Certification and Program Monitoring: Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

State Role in Funding Community-Based Services: The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

Services/Supports Overview: The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use problems, and Alzheimer's disease and/or other dementia. It is our goal to improve the lives of Mississippians by supporting a better tomorrow...today. The success of the current service delivery system is due to the strong, sustained advocacy of the Governor, the State Legislature, the Board of Mental Health, the Department's employees, consumers and their family members, and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

Service Delivery System: The mental health service delivery system is comprised of three major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

State-Operated Programs: DMH administers and operates state behavioral health programs, a mental health community living program, a specialized behavioral health program for youth, regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use disorders. These programs include: Mississippi State Hospital and its satellite program Specialized Treatment Facility; East Mississippi State Hospital and its satellite programs - North Mississippi State Hospital, South Mississippi State Hospital and Central Mississippi Residential Center. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, East Mississippi State Hospital provides transitional, community-based care. The programs for persons with intellectual and developmental disabilities provide residential services. The programs also provide licensed homes for community living. These programs include: Boswell Regional Center and its satellite program Mississippi Adolescent Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

Regional Community Mental Health Centers (CMHCs): The CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs.

Other Nonprofit/Profit Service Agencies/Organizations: These agencies and organizations make up a smaller part of the service system. They are certified by the DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

Administration of Community-Based Mental Health Services

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies. The DMH is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in, and/or facilitates numerous avenues for ongoing communication with consumers, family members, and services providers.

State Mental Health Agency's Authority in Relation to Other State Agencies: The DMH is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance use services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan. .

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS	
Region 1: Coahoma, Quitman, Tallahatchie, Tunica	Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267
Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	LIFECORE Health Group Ricardo Fraga, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Timber Hills Mental Health Services Jason Ramey, Interim Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883

Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower, Washington, Sharkey, Bolivar, Issaquena	Life Help Phaedre Cole, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211
Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston	Community Counseling Services Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347
Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)
Region 9: Hinds	Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director 3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	Southwest MS Mental Health Complex Sherlene Vince, Executive Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Shelley Foreman, LPC, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132

Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Behavioral Health, Inc. Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Strengths and Needs of the Service System

Strengths: Children with Serious Emotional Disturbance (SED) and Their Families

- Project XPand, a four year System of Care Expansion and Sustainability Agreement, ended June 30, 2017, serving 449 youth. One local community mental health center region implemented the program in two counties which provided evidence based practices, training for professionals and youth, and education and resources for transitional aged youth, 14-21 years. DMH was recently awarded another Cooperative Agreement to begin October 1, 2017, which will focus on youth who are involved with the child welfare and/or juvenile justice systems, referred to as "crossover youth".

- The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances and complex needs that usually require the intervention of multiple state agencies. The DMH provides flexible funding to this state-level team and to local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Child Protection Services (CPS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services.

- The DMH and the Division of Children's Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training staff from other child and family support service agencies. Collaborative training initiatives include Wraparound Facilitation and System of Care by the Mississippi Wraparound Institute; Youth Suicide Prevention; Cultural Diversity; Trauma-Informed Care; nonviolent crisis intervention (CPI); and contractual services with nationally certified trainers and learning collaboratives for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. The DMH continues to fund ten CMHCs for the provision of mental health services in the local detention centers. Services include assessments, Community Support Services, SPARCS (group therapy), Cognitive Behavioral

Therapy (CBT), Wraparound Facilitation, and medication monitoring as well as training of juvenile detention center staff.

- The DMH, in collaboration with the Division of Medicaid and the University of Southern Mississippi's School of Social Work, developed the Mississippi Wraparound Institute (MWI). MWI employs and/or supports four nationally certified Wraparound Coaches to train, implement and expand high fidelity Wraparound Facilitation across the state. Currently, twelve mental health providers are certified by DMH to provide Wraparound Facilitation to over 1,700 children/youth annually.

- Through a Bringing Recovery Supports to Scale (BRSS-TACS) initiative, DMH along with partners, family members, and parents developed a specialized curriculum for Parents and Caregivers. This curriculum has been incorporated into the existing Certified Peer Support Specialists training with modules specifically designed for Parents/Caregivers such as Children's Mental Health 101; System Navigation for Access; Effective Advocacy and Collaboration Skills; Documentation; and Overview of the Education System.

- NAVIGATE is an evidence-based program designed to assist youth and young adults who have experienced their first psychiatric episode. NAVIGATE is used in conjunction with PACT services to identify and alleviate future episodes.

Needs: Children with Serious Emotional Disturbance (SED) and Their Families

- Decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers. Availability of additional workforce, particularly psychiatric/medical staff at the local community level, specializing in children's services, is an ongoing challenge in providing and improving services.

- Address children with co-occurring disorders of serious emotional disturbance (SED) and intellectual and developmental disabilities (IDD) in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross-system collaboration and education.

- Continue work to improve the information management system to increase the quality of existing data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Expand intensive home- and community-based services, such as the Division of Medicaid's MYPAC program, to additional providers in the state. Mississippi Youth Programs Around

the Clock (MYPAC) is an all-inclusive home and community- based program that assists children and youth up to the age of twenty-one (21) with serious emotional disturbance (SED) in gaining access to needed mental health services. The MYPAC program follows the high fidelity Wraparound process and is offered as an alternative to traditional Psychiatric Residential Treatment Facilities (PRTF).

- Continue to expand and explore financing options to sustain System of Care programs with other child-serving systems such as juvenile justice and child protection services. DMH, other system partners, and certified providers will need to address any changes to Medicaid that will have an impact on children's behavioral health services. DMH will continue to collaborate with the two behavioral health managed care organizations to improve access to appropriate services

Strengths: Services for Adults with Serious Mental Illness (SMI)

- Implementation of the comprehensive service system for adults with serious mental illness reflects the DMH's long-term commitment to providing services, as well as supports, that are accessible on a statewide basis.

- Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24–hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and are trained in de-escalation techniques.

- The DMH funds seven , 16–bed CSUs and partially funds one, 24–bed CSU throughout the state. The DMH also partially funds one, 8–bed CSU for adolescents. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

- The DMH also operates two, 50–bed acute psychiatric hospitals for adults. The acute care/crisis services are located in the north and in the south part of the state.

- The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. MCeRTs assess adults and children with mental illness, substance use, and intellectual and developmental disabilities. MCeRTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.

- The perspectives of families and individuals receiving services are important in planning, implementing, and evaluating the adult service system through involvement in numerous task forces, peer review process, provider education, and the person-directed planning process. Initiatives have been implemented to provide more specific guidance regarding the

purpose and structure of local advisory councils. A draft of a manual has been developed to provide technical assistance to the local advisory councils. A strategy to disseminate educational information to the local councils is also being developed.

- The Bureau of Community Services coordinates the Peer Support Specialist Program. This program is designed to promote the provision of quality Peer Support Services and to enhance employment opportunities for individuals with serious mental illness, substance use, and intellectual/developmental disabilities. Certified Peer Support Specialists are required by the DMH to be an integral component of PACT and MCeRT.

- The Bureau of Community Services oversees the Peer Review Process for the DMH using The Council on Quality Leadership's Personal Outcome Measures © to assess the impact of services on the quality of life for the people receiving services. Individuals and family members are trained to conduct interviews to determine if outcomes are present for the individual and if the supports needed are present in order to achieve those outcomes. The Bureau of Community Services maintains the commitment to ensure individuals and family members have the skills and competencies needed for meaningful participation in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs.

- The Office of Consumer Support is responsible for maintaining a 24–hour, 7–days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide Prevention Lifeline. The Office of Consumer Support responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.

- The DMH is in our third year of a grant from SAMHSA which addresses housing and support service needs of persons who are experiencing chronic homelessness who have a substance use or co-occurring use and mental health disorder through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

- The DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. The sites are in Regions 2, 7, 10, and 12.

- Trainers in both the adult and youth versions of Mental Health First Aid have been certified by the DMH. Mental Health First Aid is an education program that helps the public identify, understand, and respond to signs of mental illness, substance use disorders and behavioral disorders. These trainers provide education to community leaders including: pastors, teachers, and civic groups, and families and friends who are interested in learning more about mental health issues.

- All DMH Behavioral Health Programs have implemented person-centered discharge practices which are in-line with the agency's transformation to a person-centered and recovery oriented system of care.

- The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.

- The Division of Alzheimer's Disease and Other Dementia provides awareness activities and educational training programs for family caregivers, direct care workers and other professional service providers, information and referral, adult day service programs, and annual education conferences. In addition, the Division works in collaboration with other state and nonprofit agencies on a variety of programs and projects such as development and implementation of the State Strategic Plan for Alzheimer's Disease, law enforcement training, adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services.

- The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets.

- The DMH has provided more than 25 Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members. ASIST is a 2-day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.

- Mississippi has eight Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto County), Region 6 (serves Leflore, Holmes, and Grenada Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

- The Specialized Planning Options to Transition Team (SPOTT) is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.

Needs: Services for Adults with Serious Mental Illness (SMI)

- For most people with a mental illness, employment is viewed as an essential part of their recovery. Most people with severe mental illness want to work as it is a typical role for adults in our society and employment is a cost-effective alternative to day treatment. Approximately 2 of every 3 people with mental illness are interested in competitive employment but less than 15% are employed due to lack of opportunities and supports.

- The DMH has chosen to develop and make available supported employment services based on the Dartmouth & Individual Placement and Supports Model (IPS). IPS supported employment helps people with severe mental illness work at regular competitive jobs of their choosing. Although variations of supported employment exist, IPS (Individual Placement and Support) refers to the evidence-based practice of supported employment.

- People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Approximately 40% of clients who obtain a job with help from IPS become steady workers and remain competitively employed a decade later.

- Continued work to increase access and to expand safe and affordable community-based housing options and housing related supports statewide for persons with serious mental illness is needed to support recovery. Accomplishing this goal will involve focusing the system response on supporting individuals to choose among community-based options for a stable home, based on their individual needs and preferences, which is consistent with the best practice of Permanent Supportive Housing (PSH).

- The DMH is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. The DMH makes grants available to a CMHC region to provide training to law enforcement to facilitate the establishment of two Crisis Intervention Teams (CIT) in the state.

- Continued focus on improving transition of individuals from behavioral health centers back to their home communities is needed. The development of strategies to better target and expand intensive supports through a team approach is being addressed. The DMH will continue to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.

- Work to improve the quality of data contained in the information management system, as well as to expand data analysis, continues. The goal is to integrate new and existing data into a comprehensive quality improvement system.

Underserved Racial and Ethnic Minority and LGBT Populations

The Mississippi Department of Mental Health addresses the needs of racial and ethnic minorities and LGBT populations in a variety of ways. The DMH staff has been trained as trainers in the California Brief Multicultural Competence Scale (CBMCS) Training Curriculum. The CBMCS Training is intensive, didactic, and interactive as well as a widely regarded training curriculum that provides tools for working with diverse populations. DMH also partnered with the Mississippi Department of Health, Health Equity Department in training staff as Train the Trainers in the curriculum, Cultural Competence in Health and Human Services. The goal of this one day training is to reduce disparities in access to public and community services through the provision of culturally and linguistically appropriate services. DMH also received technical assistance regarding cultural and linguistic competence from The Department of Child &Family Studies (CPS) at the University of South Carolina. In addition, the Department of Mental Health collaborated with System of Care communities to create a Behavioral Health Disparities Impact Statement. This statement describes a plan of how grantees will use data to monitor disparities and implement strategies to improve access, service use, and outcomes among the disparate population.

To address LGBT populations, the Department of Mental Health funded a LGBTQ Youth Resource Guide developed by Rise Above for Youth, a local LGBTQ Youth Advocacy and Training Agency. This Guide is available in print and on DMH's website. DMH also partners with the Mississippi Safe Schools Coalition which provides Safe Zone training to communities across the state including current System of Care grantee sites. Safe Zones provide LGBTQ youth with an environment that is supportive, understanding, and trustworthy. Staff are trained and prepared to provide youth in need with help, advice, or simply, someone to listen. The Mississippi Department of Mental Health sponsors an Annual Statewide Trauma Conference which has approximately 600 individuals attend from various disciplines serving individuals affected by trauma and mental health issues. In September of 2015, a new component was added to the conference to specifically inform and train law enforcement officers across our state. Breakout sessions on LGBTQ are infused in the conference to include trauma implications of LGBT and best practices.

American Indians

The Mississippi Department of Mental Health and the Mississippi Band of Choctaws collaborate to promote mental health awareness and education. Staff from the Mississippi Band of Choctaws Behavioral Health Services participate and assist in planning the Annual Statewide Trauma Conference sponsored by DMH. Additionally, a staff member from the Mississippi Band of Choctaws Behavioral Health Services participates on the DMH Multicultural Task Force. The mission of this task force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. In turn, staff from DMH participates and assists in planning the Annual Youth Conference sponsored by

Choctaw Behavioral Health Services. Choctaw Behavioral Health Services also participated in a train the trainer workshop on the California Brief Multicultural Competence Scale (CBMCS), which as previously stated, is a training curriculum that provides tools for working with diverse populations. The local governance council with a System of Care community also includes a representative from the Mississippi Band of Choctaws Behavioral Health Services. An individual interested in or in need of mental health services can find contact information for the Mississippi Band of Choctaws Behavioral Health Services on the current Mississippi Department of Mental Health Website.

Persons with Disabilities

Children and youth with disabilities, such as hearing and/or visual impairments, are served initially by local MAP (Making a Plan) Teams. If local resources are unavailable, the child or youth is referred to the State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, and includes representatives from the Department of Mental Health; the Department of Child Protection Services; the Division of Medicaid; the Attorney General's Office; the Department of Health; the Department of Education, the Department of Rehabilitation Services and Families As Allies for Children's Mental Health. The team meets once a month and on an as-needed or emergency basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need specialized or support services. Representatives from the Mississippi School for the Deaf and Blind participate as needed on the team and work in collaboration with staff from the Division of Children and Youth Services to develop appropriate plans to meet the needs of children and youth in our state with hearing and visual challenges.

Military Men and Women

While our military and its members are strong, there are times when they too struggle with stress, anxiety, depression and even thoughts of suicide. Sometimes military men and women feel embarrassed or ashamed to seek help and others may not know what help is available. Members of the military make a promise to protect our country. Mississippians are now making a promise to support them when they are on and off the field of battle. The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families. The campaign, Operation Resiliency, reaches National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. Stress can be a part of everyday life for many people. However, members of the military can face a constant and severe stress that many civilians may never know. It can lead to depression, anxiety, relationship problems, aggression, thoughts of suicide, financial problems, accidents, alcohol and drug use, domestic violence and hopelessness. It is important for members of the military to understand when to seek help.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service System

Adults
An adult with SMI refers to persons ages 18 and older; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Crisis Response
Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24–hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and trained in de-escalation techniques. MCeRT Teams are available in all 14 community mental health center regions. CIT teams are located in Desoto County, Jones County, and Lauderdale County.

Crisis Stabilization Units
The DMH funds seven, 16–bed CSUs and partially funds one, 24–bed CSU throughout the state. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

Housing
The Creating Housing Options in Communities for Everyone (CHOICE) program is funded by the State of Mississippi. It is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and Mississippi's Community Mental Health Centers. The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance, with supportive mental health services through Integrated Supportive Housing. Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program.

PACT Teams
Mississippi has eight Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto County), Region 6 (serves

Leflore, Holmes, and Grenada Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

Supported Employment
The DMH utilized legislative appropriated community expansion general funds to provide 4 pilot program sites (Regions 2,7,10, and 12) to begin implementation of supported employment services for adults living with mental illness in Mississippi. The DMH collaborates with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental illness. In October 2015, DMH added 4 additional employment sites through the Cooperative Agreement to Benefit Homeless Individuals (CABHI) Enhancement (4, 8, 9, and 14).

Older Adults
The Division of Alzheimer's Disease and Other Dementia provides awareness activities and educational training programs for family caregivers, direct care workers and other professional service providers, information and referral, and adult day service programs. These day service programs are community-based programs designed to meet the needs of adults with physical and psychosocial impairments. There are currently two programs operating in the state. The Division works in collaboration with other state and nonprofit agencies on a variety of programs and projects such as development and implementation of the State Strategic Plan for Alzheimer's Disease, law enforcement training, adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services. The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets. Components of this training were included into the curriculum for part-time academies this year. Additionally, Senior Psychosocial Rehabilitation Programs are offered through the CMHCs and include structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs.

Intensive Community Support Service
Intensive Community Support Services are a key part of the continuum of mental health services and supports for people with serious mental illness. Intensive Community Support Services promote independence and quality of life through the coordination of appropriate services and the provision of constant and on-going support as needed by the consumer. The direct involvement of the consumer and the development of a caring, supportive relationship between the Intensive Community Support Specialist and the consumer are integral components of the Intensive Community Support process. Intensive Community Support Services is responsive to consumers' multiple and changing needs, and plays a pivotal role in coordinating required services from across the mental health system as well as other service systems (i.e., criminal justice, developmental services, and addictions). The priority population for intensive

community support services is people who meet the definition for serious mental illness and require on-going and long-term support. Intensive Community Support Services are distinguished from usual Community Support Services by engagement in community settings of people with severe functional impairments traditionally managed in hospitals, an unusually low client to staff ratio, multiple visits per week as needed (high intensity input), and interventions primarily in the community rather than in office settings. Intensive Community Support Services are currently being offered at all 14 of our CMHC's.

Psychosocial Rehabilitation Services (PSR)
Psychosocial Rehabilitation Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. PSR is a core service and is offered at the 14 CMHCs and 3 private providers.

Recovery Supports
The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented. Recovery Supports include Certified Peer Support Specialists who are employed by DMH certified programs to work with individuals receiving services in achieving their hopes, dreams, and goals, assist the DMH Certification Team in conducting certification visits of DMH certified providers, and provide training in conjunction with DMH staff on Recovery-Oriented System of Care. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Personal Outcome Measures (POM) are a powerful tool for evaluating personal quality of life and the degree to which providers individualize supports to facilitate outcomes. The results from POM interviews give a voice to people receiving services. All CMHCs in the state participate in the POM interview process. The data is compiled and utilized to strengthen Mississippi's efforts to transform to a person centered, recovery-oriented system of care. DMH also supports the operation of the Association of Mississippi Peer Support Specialists (AMPS).

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

Children and Youth
Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI was utilized to calculate the estimate of prevalence of serious emotional disturbance among children and adolescents in Mississippi. According to URS Table 1, the estimated number of children, ages

9–17 years in Mississippi in 2015 is 368,956. Mississippi remains in the group of states with the highest poverty rate (25.7% age 5–17 in poverty, based on URS Table 1). Therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2015 are as follows:

- Within the broad group (9–11%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 11–13% or from 40,585 – 47,984.

- Within the more severe group (5–7%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 7–9% or from 25,827 – 33,206.

Adults

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi. According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years and above is 5.4 % or 2,250,779 in 2015.

The following table shows the number of adults (age 18 and above) and children (17 and below) who received mental health services during the State FY periods indicated in the tables (DMH Annual Reports, FY 2014 and FY 2015)

State Fiscal Year	Under 18	18 and older
FY 2015	35,221	62,309
FY 2016	37,694	61,298

Criterion 3: Children's Services

Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the current DSM and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills as indicated by an assessment instrument approved by DMH. The need for mental health as well as other special needs services and supports is required by these children/youth and families at a more intense rate and for a longer period than children/youth with less severe emotional disorders/disturbance in order for them to meet the definition's criteria.

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 14 community mental health/IDD commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, intensive home/community-based services, family education and prevention/early intervention services. Public inpatient services are provided directly by the DMH (described further later under this criterion). The DMH remains committed to preventing and reducing hospitalization of individuals by increasing the

availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State-Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Mobile Crisis/Emergency Response Teams, Medication Maintenance, Intensive Home/Community Based Services, Wraparound Facilitation, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early and Periodic Screening and Diagnostic Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group, and psychological and developmental evaluations.

Interagency Collaboration for Children and Youth with SED

Interagency collaboration and coordination of activities is a major focus of the Department, the Division of Children and Youth Services and the Planning Council, and exists at the state level and in local and regional areas, encompassing needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives explained below are the State-Level Interagency Case Review/ MAP Team, the Making A Plan (MAP) Teams, the Executive Steering Committee (ESC) for all System of Care programs and participation in a variety of state-level interagency councils and committees.

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Child Protection Services, Department of Health, Department of Education, the Attorney General's Office, Families As Allies for Children's Mental Health, Inc., ***Cenpatico, and Optum Behavioral Health***. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Non-profit children's behavioral health providers, local law enforcement, youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. This wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 14 community mental health regions across the state.

The Executive Steering Council acts as the Executive Council for the Mississippi System of Care Grants, Mississippi State Youth Treatment Enhancement and Dissemination Project (SYT-ED) and other grants, as approved by the ESC, to provide technical assistance and guidance to the local project sites; and to provide leadership for the management and operation of the projects. In addition to other tasks, this committee meets monthly and participates on the subcommittees of the Statewide Affinity Group, ensures that effective support and technical assistance are provided to the grantee, votes on budget issues, and advocates on a youth's behalf or on behalf of other youth and families who may not have found their voice. Membership of the council ~~committee~~ includes DMH Director or designee of the Division of Children and Youth Services, Bureau of Alcohol and Drug Services, Bureau of Community Services, a Chairperson and Co-Chairperson, at least one local-level Project Coordinator, and at least one representative from family advocacy networks, a faith-based organization, a juvenile justice entity, the Attorney General's Office, the MS Department of Child Protection Services, the MS Department of Education, the MS Department of Vocational Rehabilitation, MS Division of Medicaid, a continuous quality improvement/evaluation entity, a post-secondary education entity, a community college, certified peer support specialist, at least one (1) youth and one (1) family/parent representative.

Provision of Evidence-Based Practices

Wraparound Initiatives in Mississippi

The Division of Children and Youth Services ***continues to partner*** with the Division of Medicaid's MYPAC Program to fund state-wide training on Wraparound Facilitation for providers of children/youth services including the community mental health centers, ***five*** non-profit organizations, parents and social workers. The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work for the Mississippi Wraparound Institute (MWI). MWI has four nationally certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. In addition, the Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT). DMH trainers provide trainings upon request to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. In FY 2016, Division of Children and Youth Services staff completed 17 suicide awareness/prevention trainings, 3 (three) A.S.I.S.T. trainings, 10 (ten) MHFA trainings and 1 (one) CIT training across the state to public schools, law enforcement officers, state agency employees, and institutions of higher learning. Three Division of Children and Youth staff continue to maintain their certification as A.S.I.S.T. Trainers.

Integrated Services for Children and Youth with SED

Initiatives to Assure Transition to Adult Mental Health Services

The Division of Children and Youth Services, the Division of Adult Community Services, and the Bureau of Alcohol and Drug Services have made a concerted effort to better address issues of youth transitioning from the child to the ***adult system***. The Executive Steering Committee has

focused on expanding the age range of children/youth identified as transitional–age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Council has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. The work of this committee and its members assisted in the development of successful grant applications for a Children's Mental Health Initiative targeting transition–aged youth which included a 6-year System of Care grant that provided funds for the implementation of 3 Transitional Outreach Programs (MTOP) across the state and a 4-year grant that expanded MTOP to 2 additional counties, Most recently, another 4-year grant that targets youth in the child welfare system and/or juvenile justice system was awarded.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services for transitional living programs that addresses the needs of youth with SED, including those in the transition age range of 16 to 21 years. DMH continues to provide certification, monitoring, and technical assistance to six (6) transitional therapeutic group homes.

Youth Education/Support Initiatives
Through ***MTOP and Project XPand***, each program site has developed Youth Leadership and Advocacy Councils. These councils meet on a regular basis to plan for fundraising events, community activities, various trainings and independent skill development. Members of these youth councils have attended and presented at national SOC grant meetings, the Georgetown Training Institutes, and FFCMH annual conferences and trainings.

Support for Services for Youth with Co-occurring Disorders
The Division of Children and Youth Services and the Bureau of Alcohol and Drug Services collaborate to include sessions on co-occurring disorders in youth at the annual MS School for Addiction Professionals. The Division of Children and Youth Services partners with the Bureau of Alcohol and Drug Services to fund and implement Adolescent Intensive Outpatient Programs serving youth with co-occurring disorders utilizing evidence-based practices such as Adolescent Community Reinforcement Approach, Wraparound Facilitation and the GAIN assessment system. Additionally, the Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance use problems which also address problems of youth with co-occurring disorders.

Criterion 4: Targeted Services to Rural and Homeless Populations

Mississippi has the Projects for Assistance in Transition from Homelessness (PATH) Program which provides services to eligible individuals who are experiencing homelessness and have serious mental illness and co-occurring substance use disorders. The focus has been on individuals who are literally homeless, living in places not meant for human habitation. Peer Support Specialists provide street outreach so workers continually interact with people. Peer

Support Specialists used lived experience to help homeless individuals believe that getting out of bad situations is possible and that home, employment, and stability are obtainable. The PATH program provides the state with funds for flexible community-based services for persons with serious mental illnesses and co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. DMH provides funding to 4 CMHC's and 1 non-profit provider.

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. Staff attends the MS United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings. The DMH continues to receive technical assistance in the implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program in Mississippi as provided by SAMHSA. The purpose of SOAR is to help states increase access to mainstream benefits for individuals who are homeless or at risk for homelessness through specialized training, technical assistance, and strategic planning for staff that provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process. The DMH provides information and oversight regarding the online training. There is an online SOAR data collection system that SOAR processors in the state are encouraged to use to report the results of the SSI/SSDI applications that are submitted using SOAR.

Criterion 5: Management Systems

Federal Block Grant Award *7/1/2016 – 6/30/2017*	
Administration Amount	***$4,674,359.00***
Set Aside	***$ 467,436.00***
Amount to be awarded	***$3,984,335.00***
Children's portion	***$1,633,577.35***
Adult portion	***$2,350,757.65***

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Identification of the Unmet Service Needs and Critical Gaps for Adults and Children

The Mississippi Board of Mental Health and the DMH developed a Strategic Plan seven years ago. The Strategic Plan was developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan was to create a living, breathing document. The Plan was developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies. The DMH wanted to make strides toward developing a community-based service system which focuses on evidence-based practices and improves access to care.

The Bureau of Community Services used the report published by Mental Health America Parity or Disparity: The State of Mental Health in America 2015, to assist us in identifying gaps in our services for adults and children. The report identifies indicators available across all fifty states and the District of Columbia. The report is organized in general categories relating to mental health status and access to mental health services. The data allows the DMH to see how our state is ranked among the other states.

- 51st for Adults with highest prevalence of mental illness and lowest rates of access to care
- 45th for Adults with any mental illness
- 28th for Adults with serious thoughts of suicide
- 50th for Adults any mental illness and uninsured
- 51st for Adults with Disability who could not see a Doctor due to costs
- 46th in mental health workforce availability

The DMH receives feedback through the review of the State Plan by the Mississippi State Mental Health Planning and Advisory Council and the Mississippi Board of Mental Health. The DMH has also benefited greatly from the continuity of its relationship with the Mississippi State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH sends out a statewide satisfaction survey for adults and children as another means of collecting feedback from individuals served by the system. Family members, consumers, local service providers, and representatives from other agencies participate on numerous task forces and coalitions.

In addition to considering estimates of prevalence for targeted groups, results of a statewide consumer survey, public forums, and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing were identified. As part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided the DMH with state level population data and various indicators of poverty and disability. While there continues to be a need for transportation and housing for targeted groups, the information and data provided by TAC has been used on occasions to educate public officials, stakeholders, and funding sources regarding the need for expanding and increasing transportation and housing. The TAC data has also been used to develop applications for funding to increase these services.

The DMH management staff receives regular reports from the Office of Consumer Support (OCS), which tracks requests for services by major category, as well as receives and attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system.

The Division of Children and Youth Services gains information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, and through the work of the State-Level Interagency Case Review Team, two SAMHSA funded initiatives, and the Mississippi Transitional Outreach Program described in more detail in the State Plan.

According to the Behavioral Health Barometer, Mississippi 2015 Report, 26,000 adolescents ages 12 to 17 (10.6% of all adolescents) per year in 2013-2014 had at least one Major Depressive Episode. Approximately 7,000 adolescents with MDE (34.0% of all adolescents with MDE) per year in 2010-2014 received treatment for their depression.

In the Mental Health America Report, Parity or Disparity: The State of Mental Health in America 2015, the following information is reported on Mississippi's rankings compared to other States:

- 42nd for youth ranking with the highest prevalence of mental illness and lowest rates of access to care
- 47th for children with emotional, behavioral and developmental issues
- 12th for youth with at least one Major Depressive Episode
- 41st for youth who attempted suicide
- 43rd for children with emotional, behavioral, and developmental issues who were consistently insured
- 46th for children who needed but did not get mental health services
- 31st for children reporting inadequate insurance
- 46th in mental health workforce availability

The 2015 Youth Risk Behavior Survey reports the following information related to violence, attempted suicides, alcohol and drug use, and risky sexual behavior:

- The percentage of students who carried a gun on one or more of the past 30 days decreased (11.6% in 2013 and 8.5% in 2015) however the percentage of students who carried a weapon such as a gun, knife, or club on school property increased (4.1% in 2013 and 5.2% in 2015).
- The percentage of students who were bullied on school property during the last 12 months increased from 19.2% in 2013 to 19.5% in 2015 which relates to the increase of students who felt unsafe at school 8.3% in 2013 and 9.0% in 2015).
- The percentage of students who ever had sexual intercourse decreased from 54.2% in 2013 to 48.0% in 2015.
- In 2015, the percentage of high school students in grades 9-12 who seriously considered attempting suicide was 17.7%. The percentage of students in grades 9-12 who made a suicide plan was 14.6%.

Access to care is an identified challenge for Mississippi's youth based on the high prevalence rate of emotional and behavioral issues. The DMH has worked diligently to increase the number of qualified providers and to expand services/programs across the state. Since the submission of the FY 2016 – 2017 MHBG application, one new provider has been certified by DMH to provide the Core Services for adults and children/youth. This provider has been certified by DMH to provide services in eight (8) locations across the central and northern part of the state. In addition to the eleven certified providers of Wraparound Facilitation, one (1) new provider of this service was recently certified by DMH.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Peer Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance the transition process of individuals to a less restrictive environment.

Objective:

Continue to utilize Peer Bridgers to improve the process for people transitioning from inpatient care to community-based care

Strategies to attain the objective:

Utilize Peer Bridgers at a behavioral health program and local Community Mental Health Centers utilizing WRAP

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Peer Bridgers

Baseline Measurement: In FY 2016: 5 (No data for FY 15 – Pilot Project)

First-year target/outcome measurement: In FY 2018: 5

Second-year target/outcome measurement: In FY 2019: 7

Data Source:

Data is collected quarterly by the 3 local CMHCs and the behavioral program and submitted to DMH

Description of Data:

Quarterly data collected includes number of Peer Bridgers employed by and tracked by the grantees which are a behavioral program and 3 local CMHCs Each of the 3 CMHCs have a full-time Peer Bridger and the behavioral program has two part-time Peer Bridgers. Services provided by Peer Bridgers will help individuals transition back into their communities and avert future potential crises

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect outcome measures.

Priority #: 2

Priority Area: Peer Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Utilize peers and family members to provide varying supports to assist individuals in regaining control of their lives and their own recovery process.

Objective:

; Increase the number of peers/family members trained as Certified Peer Support Specialists (CPSS).

Strategies to attain the objective:

• Conduct outreach to stakeholders to increase the number of CPSS and the role of CPSSs
• Provide training and technical assistance to service providers on the Recovery Model, Person Centered Planning, and System of Care Principals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number CPSSs employed by DMH certified providers

Baseline Measurement: In FY 2015: 36

First-year target/outcome measurement: In FY 2018: 176

Second-year target/outcome measurement: In FY 2019: 196

Data Source:

Data is submitted quarterly to DMH from the DMH certified providers employing Certified Peer Support Specialists.

Description of Data:

Data is collected quarterly from all DMH certified providers employing Certified Peer Support Specialists In FY 2016, 30 DMH certified providers employed 36 Certified Peer Support Specialists.

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 3

Priority Area: Community Support for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements

Objective:

Utilize Programs of Assertive Community Treatment (PACT) Teams to help individuals who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient services.

Strategies to attain the objective:

Increase the number of admissions to PACT Teams

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions to PACT Teams

Baseline Measurement: In FY 2015: 97

First-year target/outcome measurement: In FY 2018: 140

Second-year target/outcome measurement: In FY 2019: 180

Data Source:

All eight PACT Teams submit data quarterly to DMH. Data includes number of admissions to PACT Team services

Description of Data:

Quarterly data is submitted by the eight PACT Teams. Data includes number of admissrons. During FY 2016, there were 85 new

admissions to PACT Teams in addition to the 164 individuals already being served

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 4

Priority Area: Community Support for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide funding to offset cost of mental health services provided to individuals with serious mental illness who have no payer source

Objective:

Provide services through the Purchase of Services Grant

Strategies to attain the objective:

Grant funding to 14 CMHCs for Purchase of Services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of units of service reimbursed by Purchase of Service Grant

Baseline Measurement: In FY 2015: 180,002 units

First-year target/outcome measurement: In FY 2018: Maintain or increase the number of units of service

Second-year target/outcome measurement: In FY 2019: Maintain or increase the number of units of service

Data Source:

The 14 CMHCs submit data monthly through cash requests and monthly reports. This data includes number of units of services provide through the POS grants.

Description of Data:

Data is collected through monthly cash requests and submitted by the 14 CMHCs/grantees

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 5

Priority Area: Crisis Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand access to crisis services and divert individuals from more restrictive environments such as jails, hospitals, etc

Objective:

Expand access to crisis services through the utilization of Mobile Crisis Response Teams.

Strategies to attain the objective:

Increase the number of contacts made by the Mobile Crisis Response Teams.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of contacts

Baseline Measurement: In FY 2015: 19,660 contacts

First-year target/outcome measurement: In FY 2018: 23,160

Second-year target/outcome measurement: In FY 2019: 25,000

Data Source:

The number of contacts by the Mobile Crisis Response Teams is submitted to DMH quarterly.

Description of Data:

Data is submitted quarterly by the Mobile Crisis Response Teams to DMH. In FY 2016, at total of 22, 768 calls were received and there were a total of
15, 442 face-to-face visits. Of the 15, 442 face-to-face visits, 9,449 had follow-up appointments scheduled at a CMHC

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 6

Priority Area: Crisis Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand access to crisis services and divert from more restrictive environments such as jails, hospitals, etc.

Objective:

Expand access to crisis services through the utilization of Crisis Stabilization Units.

Strategies to attain the objective:

Track the number of admissions to the Crisis Stabilization Units

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions

Baseline Measurement: In FY 2015: 3,609 admissions

First-year target/outcome measurement: In FY 2018: 3,200

Second-year target/outcome measurement: In FY 2019: 3,300

Data Source:

Quarterly data, which includes number of admissions, is submitted by the CSUs to DMH

Description of Data:

Crisis Stabilization Units submit data quarterly to DMH which includes the number of involuntary and voluntary admissions. In FY 2016, the CSUs served 3,270 individuals, which is a decrease from the number served in FY 2015. This decrease in the number served is attributed to the increase of individuals in crisis being served by the Mobile Crisis Response Teams

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 7

Priority Area: Supported Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Connect adults with serious mental illness to appropriate housing opportunities

Objective:

Increase the availability of community supports/services for people with a serious mental illness in order to implement the Permanent Supportive Housing model.

Strategies to attain the objective:

Ensure that people with a serious mental illness who are housed as a result of the Permanent Supportive Housing model have the opportunity to live in the most integrated settings in the community of their choice by providing an adequate array of community supports/services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of assessments provided, Number of people maintained in permanent supportive housing

Baseline Measurement: In FY 2016: 48 assessments provided; 48 individuals maintained in permanent supportive housing

First-year target/outcome measurement: In FY 2018: 200 assessments provided, 200 individuals maintained permanent supportive housing

Second-year target/outcome measurement: In FY 2019: 300 assessments provided, 300 individuals maintained permanent supportive housing

Data Source:

The six CMHCs operating CHOICE programs submit quarterly data to DMH

Description of Data:

Data will be submitted quarterly to DMH to include the number of assessments provided and the number of individuals maintained in Permanent Supportive Housing The CHOICE program began in March 2016 with programs being operated by six CMHCs Since March 2016, 48 assessments have been provided, and 48 individuals have received housing through this program A variety of services are provided to these individuals including outpatient services, peer support, PACT, physician services, community support, intensive case management, and/or psychosocial rehabilitative services .

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 8

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Utilize MAP Teams to help serve children and youth in their community and prevent unnecessary institutionalizations

Objective:

Increase the number of children and youth served by MAP Teams

Strategies to attain the objective:

Technical assistance will be provided to MAP Teams as requested and/or needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number served by MAP Teams

Baseline Measurement: In FY 2015: 1,079

First-year target/outcome measurement: In FY 2018: 1,200

Second-year target/outcome measurement: In FY 2019: 1,400

Data Source:

Cash requests and data, including number of children and youth served, are submitted monthly to DMH by the MAP Team Coordinators.

Description of Data:

In FY 2016, there were 55 MAP Teams serving 62 counties A total of 1,152 children and youth were served by MAP Teams in FY 2016. Monthly reports are submitted to DMH by MAP Team Coordinators which include the number of children and youth served Cash requests are also submitted monthly to DMH which lists the services and supports funded for the children and youth served by the MAP Teams.

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 9

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase statewide use of Wraparound Facilitation with children and youth

Objective:

Increase the number of children served by Wraparound Facilitation

Strategies to attain the objective:

Increase statewide use of Wraparound Facilitation with children and youth through training and supports provided by the Mississippi Wraparound Institute. .

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children served by Wraparound Facilitation

Baseline Measurement: FY 2015: 1,078

First-year target/outcome measurement: FY 2018: 1,700

Second-year target/outcome measurement: FY 2019: 1,900

Data Source:

Data which includes the number of children and youth served with Wraparound Facilitation is submitted quarterly to DMH by MWI.

Description of Data:

A total of 11 providers were certified to provide Wraparound Facilitation in FY 2016, and a total of 462 individuals were trained. The Mississippi Wraparound Institute (MWI) employs two of the four nationally certified Wraparound coaches in the state to provide training and supports to certified providers of Wraparound Facilitation in Mississippi. Data is submitted quarterly to DMH by MWI. In FY 2016, 2,960 children and youth were served with Wraparound Facilitation.

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Priority #: 10

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED, ESMI

Goal of the priority area:

Assist youth and young adults in navigating the road to recovery from First Episode Psychosis (FEP), including efforts to function well at home, on the job, at school and in the community through the Coordinated Specialty Care Team

Objective:

Increase the number of youth and young adults served through the NAVIGATE Program

Strategies to attain the objective:

Continue an evidenced-based intervention program for youth and young adults who have experienced First Episode Psychosis (FEP)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults served through the NAVIGATE Program

Baseline Measurement: In FY 2016: 4 (No data for FY 15 – Pilot Project)

First-year target/outcome measurement: In FY 2018: 16

Second-year target/outcome measurement: In FY 2019: 20

Data Source:

Number of youth and young adults served through the NAVIGATE Program is submitted monthly to DMH by the two CSC teams.

Description of Data:

The initial Coordinated Specialty Care (CSC) team funded by the 5% Set Aside is operated by a CMHC located in the north central portion of the state. That program served 4 young adults in FY 2016. An additional CSC team has been developed and is provided funding utilizing the 10% Set Aside to provide services through the NAVAGATE program to youth and young adults living on the Gulf Coast. Data is submitted monthly to DMH by the two CSC teams which includes the number of youth and young adults served through the NAVIGATE Program.

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 11

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide services through the Juvenile Outreach Program (JOP) that are necessary for a youth's successful transition from a detention center back to his/her home and/or community.

Objective:

Decrease the number of re-entries to the detention centers.

Strategies to attain the objective:

Continue funding to CMHCs to make mental health services available to youth in detention centers in an effort to prevent re-entries.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number served in detention centers
Baseline Measurement:	FY 2017: Baseline data gathered
First-year target/outcome measurement:	FY 2018: 1200
Second-year target/outcome measurement:	FY 2019: 1,300

Data Source:

Data is submitted monthly by the CMHCs receiving JOP grant funding

Description of Data:

Currently, ten CMHCs receive grant funding to provide services through the Juvenile Outreach Program (JOP) These programs provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center which include immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, and individual therapy. Monthly data is submitted to DMH from the CMHCs receiving grant funding to provide services through the Juvenile Outreach Program

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect outcome measures

Priority #: 12

Priority Area: Community Integration

Priority Type: SAT, MHS

Population(s): SMI

Goal of the priority area:

Provide treatment and supports to improve the successful reentry of incarcerated people into the community

Objective:

Increase treatment and recovery support services for people with co-occurring mental health and substance use disorders transitioning from incarceration back into the community.

Strategies to attain the objective:

Implement a program that provides recovery support services to individuals with co-occurring mental health and substance use disorders who are returning to Hinds County and identified as medium to high risk for recidivism

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of individuals identified as having co-occurring disorders successfully completing intensive outpatient treatment program
Baseline Measurement:	In FY 2017: Baseline data gathered

First-year target/outcome measurement: In FY 2018: 30

Second-year target/outcome measurement: In FY 2019: 50

Data Source:

Quarterly data will be submitted by DMH Behavioral Health programs including the number of individuals diverted from wait lists to community-based programs

Description of Data:

Quarterly data will be submitted by DMH Behavioral Health programs including the number of individuals diverted from wait lists to community-based programs

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 13

Priority Area: Supported Employment

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Develop employment options for adults with serious and persistent mental illness

Objective:

Increase the number of individuals who are gainfully employed

Strategies to attain the objective:

Legislative appropriated community expansion general funds will be utilized to provide 4 pilot program sites to begin implementation of supported employment services for adults living with mental illness. Collaboration with Vocational Rehabilitation Services will take place

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals with serious and persistent mental illness who are gainfully employed

Baseline Measurement: In FY 2016: 102

First-year target/outcome measurement: In FY 2018: 120

Second-year target/outcome measurement: In FY 2019: 140

Data Source:

Four program sites submit data quarterly to DMH including the number of individuals with serious mental illness who are employed.

Description of Data:

In FY 2016, four program sites were funded to make available supported employment options for adults with mental illness These four sites submit data quarterly to DMH including the number of individuals with serious mental illness who are employed During FY 2016, 2,723 business contacts to potential employers were made resulting in 165 job placements By the end of FY 2016, 102 individuals with serious mental illness remained employed

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 14

Priority Area: Recovery Supports

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand the peer review/quality assurance process by utilizing Personal Outcome Measures (POM) interviews to measure outcomes of individuals receiving services.

Objective:

Improve access and outcomes of services to people receiving services through data gathered in POM interviews

Strategies to attain the objective:

Offer technical assistance to providers after POM reports are released to providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of POMs completed at each CMHC

Baseline Measurement: In FY 2015/16: 350

First-year target/outcome measurement: In FY 2018: 15 per visit for the 14 CMHCs

Second-year target/outcome measurement: In FY 2019: 15 per visit for the 14 CMHCs

Data Source:

The number of Personal Outcome Measure (POM) Interviews completed during each certification visit to the CMHCs will be tracked and submitted to DMH quarterly

Description of Data:

The number of Personal Outcome Measure (POM) Interviews completed during each certification visit to the CMHCs will be tracked and submitted to DMH quarterly Certified Peer Support Specialists participate on the Certification Visit Team and conduct the interviews during scheduled certification visits Results of the POM interviews are released to the provider and technical assistance is offered based on the results of the report

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures

Priority #: 15

Priority Area: Recovery Supports

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Strengthen family education and family support capabilities in the state

Objective:

Increase recovery supports to individuals through family education and family support provided y NAMI-MS funded by DMH

Strategies to attain the objective:

Provide a variety of training and workshops targeting people with SMI and family members throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Number of training and workshops
Baseline Measurement:	In FY 2015: 110 workshops/support groups/trainings provided by NAMI
First-year target/outcome measurement:	In FY 2018: 125 workshops/support groups/trainings provided by NAMI
Second-year target/outcome measurement:	In FY 2019: 135 workshops/support groups/trainings provided by NAMI

Data Source:

The number of trainings and workshops provided by NAMI-MS to individuals with SMI and family members of individuals with SMI and children and youth with SED. This data is submitted quarterly.

Description of Data:

NAMI-MS submits data quarterly to DMH regarding the number of trainings and workshops provided to individuals with SMI and family members of individuals with SMI and children and youth with SED DMH funds NAMI-MS to provide recovery support services to individuals with serious mental illness and family members of children and youth with SED by offering trainings and workshops on issues surrounding their mental health challenges.

Data issues/caveats that affect outcome measures::

There are no data issues or caveats expected to affect the outcome measures.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$8,326,567	$0	$19,805,666	$59,393,646	$0	$0
8. Mental Health Primary*		$0	$0	$0	$0	$0	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$976,860	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$465,171	$0	$0	$0	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	**$0**	**$9,768,598**	**$0**	**$19,805,666**	**$59,393,646**	**$0**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$0			
2. Infrastructure Support	$0			
3. Partnerships, community outreach, and needs assessment	$0			
4. Planning Council Activities (MHBG required, SABG optional)	$0			
5. Quality Assurance and Improvement	$0			
6. Research and Evaluation	$0			
7. Training and Education	$0			
8. Total	**$0**	**$0**	**$0**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[25] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102?123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders I Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52?77

[26] Research Review of Health Promotion Programs for People with SMI, 2012, http://www integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts, http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www integration samhsa.gov/health-wellness/samhsa-10x10; Schizophrenia as a health disparity, http://www.nimh.nih gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[27] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al , Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013 3726; http://www.samhsa gov/co-occurring/

[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

[31] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011 http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[32] Health Care Integration, http:// samhsa gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www Integration.samhsa.gov/)

[33] Health Information Technology (HIT), http://www integration samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www integration.samhsa.gov/operations-administration/telebehavioral-health; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[34] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[36] Waivers, http://www medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

[37] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list html

[38] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles html; About the Compact of Free Association, http://uscompact org/about/cofa.php

[39] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[40] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs, 2014; 33(4): 700-707

[41] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform JAMA Psychiatry 2013, 70(10):1084-1090; JW Boyd et al The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston Annals of Emergency Medicine 2011; 58(2): 218

[42] Hoge, M A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M & Goplerud E Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012 html

[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft. August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/ccIio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings

   The DMH envisions a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports. The DMH is committed to maintaining a statewide comprehensive system of prevention, treatment and rehabilitation which promotes quality care, cost effective services, and ensures the health and welfare of individuals. Presently, integrated mental health, substance use and primary health care services are not all available at the same location on a statewide basis. However, in 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue In 2011, 2012, and 2015, DMH submitted grant applications to SAMHSA and CMH to develop initiatives to integrate mental health and primary healthcare Although none of these grant applications were successful, the opportunities for collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-

occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability

Collaborative activities involving mental health and/or substance use, primary health, and other support service providers include:

A representative from the Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State-Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) Teams across the state

As part of their application to the DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services.

The DMH Division of Recovery and Resiliency is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across Bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Providers.

The DMH Division of Alzheimer's Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.

The DMH Bureau of Alcohol and Drug Services continues to work with the Attorney General's Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner

The DMH Bureau of Alcohol and Drug Services partners with the MS Department of Rehabilitation Services to fund substance use treatment services to individuals in transitional residential programs

The DMH Bureau of Alcohol and Drug Services works collaboratively with the MS Band of Choctaw Indians and continues to fund prevention services with Choctaw Behavioral Health

The DMH Bureau of Alcohol and Drug Service has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. Through this partnership, trainings are provided around the state. The training is also available for A&D personnel located at community mental health centers.

The DMH Bureau of Community Services' Annual Provider Survey gathers self-reported information on integrated primary and behavioral health care, as well as on tele-medicine opportunities

In December 2014, the DMH Bureau of Community Services and the DMH Bureau of Outreach, Planning and Development applied for and were awarded membership in the SAMHSA-HRSA Center for Integrated Health Solution's (CIHS) Innovation Community entitled Building Integrated Behavioral Health in a Primary Care Setting. This collaboration is between the DMH, a local CMHC, and a local FQHC.

In March 2015, the DMH Division of Recovery and Resiliency applied for and was awarded a 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Subcontract for the Expansion of Policy Academy Action Plans.

In October 2016, the Department of Mental Health partnered with the Department of Health and the Mississippi Public Health Institute for a State Forum on Integrated Care One of the outcomes of the forum was to develop a document to help guide integrated care in Mississippi as we move forward The Roadmap for Integrated Care in Mississippi has been completed and is now available. Forum participants developed practical strategies for innovative health system transformation as detailed in the action plan in Section III of the document. These components will serve as the foundation for the Roadmap to Integrated Care in Mississippi. DMH's Integration Work Group served as the advisory committee for the State Forum event

DMH's Integration Work Group is a multidisciplinary, interagency work group which was created in August 2011 for the purpose of developing strategies and partnerships to facilitate the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care to create a holistic approach to care.

In addition, the DMH has funded the development of eight PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists)

Health information is obtained for all individuals seeking services from the DMH certified providers on the Initial Assessment A medical examination is required for individuals in supervised and residential programs, as well as in senior psychosocial programs. Also, Certified Peer Support Specialists are trained to assist individuals receiving services in accessing all health care services.

Four Community Mental Health Centers report working directly with their local Community Health Center to provide primary care and other medical services; two of those Community Mental Health Centers have a formal agreement with the Community Health Center. One Community Mental Health Center reports that they provide primary health care services at the CMHC. LIFECORE Health Group/ Region 3 Mental Health Center located in Tupelo, Mississippi, serves seven counties and is a comprehensive health system. The main center in Tupelo is a ten thousand square foot building devoted to the co-location and integration of primary health care and behavioral health care services. Included in this facility is a pharmacy which provides both medical and psychotropic medication for all its clients Additionally, Region 3 operates a mobile primary care unit which travels to four counties in its region.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

   and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   The Mississippi Department of Health

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ○ Yes ◉ No

   b) Health risks such as

      i) heart disease ○ Yes ◉ No

      ii) hypertension ○ Yes ◉ No

      viii) high cholesterol ○ Yes ◉ No

      ix) diabetes ○ Yes ◉ No

   c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ◉ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   On April 17-18, 2017, two staff from the Mississippi Department of Mental Health participated in the Parity Academy for Commercial Insurance at SAMHSA In Mississippi, the list of issues and problems are extensive on the Commercial side The Division of Medicaid in Mississippi does not currently reimburse for substance use services

10. Does the state have any activities related to this section that you would like to highlight?

    All DMH certified providers are required to complete Initial Assessments for individuals seeking services This assessment documents pertinent information that is used as part of the process for determining what service or combination of services might best meet an individual's stated/presenting need(s). Individuals seeking services are asked questions regarding medical history, developmental history for children and youth, family history of medical conditions, and current chronic medical conditions or diseases such as sleep and appetite issues, hypertension, diabetes, thyroid or other medical conditions. DMH certified providers are required to make referrals to appropriate services or other mental health or medical services providers based on the information obtained during the Initial Assessment.

    Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopuletions or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	( ) Yes (•) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (•) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (•) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care? ( ) Yes (•) No

7. Does the state have any activities related to this section that you would like to highlight?

   The Cultural Competency Plan Implementation Workgroup recommended inclusion of language and proficiency in the DMH data collection standards including questions regarding primary language spoken by the individual, language preferred by the individual, language written by the individual, and whether or not the individual receiving services needed an interpreter. Due to funding constraints, the Workgroup was informed that additional questions to the current data collection system are currently not possible. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible When cultural competency trainings are conducted in the state, the Cultural and Linguistic Competency Training Evaluation form includes a sexual orientation question. The data from the form is placed in a comprehensive report for the training results The current DMH Central Data Repository does not address or track language needs. Language needs are addressed by creating a comprehensive list of translators and interpreters in Mississippi as well as a list of resources for alternate forms of communication for individuals with hearing, visual and/ or other disabilities. These two lists have been mailed to programs to assist with providing language needs. The state has a State Plan for Cultural Competency, which includes workforce-training. The state provides trainings on cultural competence, CLAS standards, and cultural diversity to DMH certified providers The state plans to provide a web-based CLAS Standards training in the future.

   Please indicate areas of technical assistance needed related to this section

   Due to budget reductions during recent legislative sessions in our state, technical assistance is needed regarding innovative ways to assist mental health providers in the implementation of CLAS Standards with limited funds.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-TC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (•) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (•) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? (•) Yes ( ) No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI

   The two programs operated by Region 6 and Region 13 CMHCs utilize the evidence-based practice, NAVIGATE, a Coordinated Specialty Care (CSC) model created under the RAISE initiative for First Episode Psychosis (FEP). DMH contracts with NAVIGATE consultants, Susan Gingerich, Shirley Glynn, and Corrine Cather to provide training and technical assistance to the two CSC teams. A two-day intensive was provided to the two NAVIGATE CSC Teams in the summer of 2016 specifically focusing on the roles of the Individual Resiliency Training (IRT) clinicians, the Supported Employment/Education (SEE) specialists, and the Family Education clinicians. The NAVIGATE consultant team continues to provide bi-monthly technical assistance telephone calls to review roles, manuals, discuss youth referred, and provide input and guidance on further program development.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   DMH funds, promotes and supports the two NAVIGATE programs described above Plans are being developed to expand this EBP of Coordinated Specialty Care Teams to another area of state The NAVIGATE curriculum and model includes individualized treatment, service plans, and coordination with physical health services.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ( ) Yes (•) No

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (•) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

NAVIGATE is a comprehensive treatment program for people who have had a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and get their life back on track. More broadly, NAVIGATE helps clients navigate the road to recovery from an episode of psychosis, including getting back to functioning well at home, work, and in the social world. NAVIGATE includes four different treatments: individualized medication treatment, family education, individual resiliency training, and supported employment and education.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

For the two (2) existing programs, the goals are to increase referrals; develop a specialized checklist for admission; identify standardized assessment tools; train new team members; and, revise the quarterly report form. DMH is making plans to implement a third team in State Fiscal Year 2019 depending on the availability of funds.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state collects data quarterly from Region 6 and Region 13. Data collected includes intakes and number enrolled, number of individuals maintained in the community, utilization of emergency rooms or psychiatric hospitalization, employment status and hours worked, school enrollment, types of services provided, and number of contacts with NAVIGATE staff.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic categories identified for Mississippi's ESMI programs are the disorders classified in the DSM-5 as Schizophrenia Spectrum and Other Psychotic Disorders which include Schizophrenia, Schizoaffective Disorder, and Schizophreniform Disorder.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   Consumers and caregivers are involved in making health care decisions and guiding the treatment and recovery process through Wraparound Facilitation, Peer Support Services, Wellness Action Recovery Plans and Individual Action Recovery Plans, and Personal Outcome Measure (POM) interviews. During Personal Outcome Measure (POM) interviews, individuals are asked about preferences including dreams and goals Individuals are asked to describe their dreams and goals In turn, providers are questioned as to how they are supporting individuals to achieve their stated dreams and goals. Regarding the 25 Quality of Life Measures, individuals are asked if they possess these qualities in their lives, and if so, are they satisfactory The Initial Assessment utilized by all DMH certified providers has been redesigned to reflect this change.

4. Describe the person-centered planning process in your state.

   The Department of Mental Health is transforming Mississippi's public mental health system into one that is person-centered and recovery-oriented. The Initial Assessment and Individual Service Plan utilized by DMH certified providers have been redesigned and now require clinicians to record individuals' hopes, dreams, and goals in the individuals' own words Training is being provided across the state to providers to enforce the importance of the person-centered and recovery-oriented process. In addition, during Personal Outcome Measure (POM) interviews, individuals are asked about their dreams and goals. Personal Outcome Measure interviews are conducted by trained Certified Peer Support Specialists and occur during certification/monitoring visits scheduled by the Division of Certification at DMH

   In Mississippi, high-fidelity Wraparound Facilitation is provided to engage children and youth and their caregivers in decisions made regarding their mental health care A key element of Wraparound Facilitation is that of family determination which means the family's perspective, preferences and opinions are first, understood; second, considered in decision making; and finally, influential in how the team makes decisions. Activities include assembling the child and family team according to the child and caregiver's preferences, facilitating a child and family team meeting at a minimum every thirty (30) days, facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, working with the team in identifying providers of services and other community resources to meet family and youth needs, and monitoring the implementation of the plan of care and revising if necessary to achieve outcomes DMH currently certifies eleven providers in the state to provide Wraparound Facilitation. Mississippi has four nationally certified Wraparound Coaches, two of which provide training and support through the Mississippi Wraparound Institute at the University of Southern Mississippi In FY 16, 2,960 children and youth were served with Wraparound Facilitation

   Peer Support is a helping relationship between peers and individuals and/or family members that is directed toward the achievement of specific goals defined by the individual Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery.

   Individuals participating in Psychosocial Rehabilitation Programs offered through the CMHCs are required to have an Individual Recovery Action Plan (IRAP) or Wellness Recovery Action Plan (WRAP). WRAP and IRAP plans are developed by the individuals and involve setting their own goals and assessing their own skills and resources related to goal attainment Goals are set by exploring

strengths, knowledge and needs in the individual's living, learning, social, and working environments

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? (•) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes (•) No

If yes, describe the currently planned initiatives In particular, please answer the following questions:

a) How is this initiative financed:

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future

Mississippi has adopted the 10 Components of Recovery and SAMHSAs definition of recovery Self-direction is one of the components that Mississippi has embraced. DMH staff provides training across the state on recovery and Recovery-Oriented Systems of Care

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? (●) Yes ( ) No

3. Does the state have any activites related to this section that you would like to highlight?

   Specific grant requirements are conveyed to Department of Mental Health service providers during the RFP process. Additionally, service providers are required to sign a packet of applicable agreements including both a list of "Federal Assurances" and Mississippi Department of Mental Health Assurances on an annual basis. Any additional requirements specific to grant funding are included in this annual packet to be signed by the program administrator annually. Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not meet the programmatic intention of the grant funds or do not meet the "necessary and reasonable" test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise

   The Department of Mental Health has an Audit Division with two major functions:
   1) Conduct annual compliance audits of grant sub-recipients Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc Audit procedures are outlined in the agencies "Central Office Audit Guide."
   2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines, reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies "Service Providers Manual" that is available on-line on the Mississippi Department of

Mental Health website.

The Division of Certification is responsible for provider certification across the three populations served by the DMH – mental health, intellectual/developmental disabilities, and substance use. The DMH currently operates on a three year certification cycle to ensure that all DMH certified providers have an on-site compliance/certification visit at a minimum of twice during that certification cycle. In addition to the on-site compliance visits, the DMH regularly conducts visits to certified providers to certify additional new programs and services. The DMH does institute a CQI process as part of its monitoring. As issues of noncompliance regarding health, safety, and programmatic standards are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues and maintain ongoing compliance. Providers develop and submit plans of compliance to the DMH for approval and subsequent implementation In turn, the DMH conducts follow up visits to ensure that corrective action is taken and remains ongoing. The DMH tracks all deficiencies to identify trends and patterns and make changes to policy as needed

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   At present, no consultation sessions have been conducted with the Mississippi Band of Choctaw Indians DMH collaboration with the Mississippi Band of Choctaw Indians is described in the activities section below

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activites related to this section that you would like to highlight?

   The DMH Bureau of Alcohol and Drug Services works collaboratively with the MS Band of Choctaw Indians and continues to certify and fund prevention services with Choctaw Behavioral Health. The Department of Mental Health continues to have an individual from the Choctaw Tribe participating on the Multicultural Task Force The Director of Choctaw Behavioral Health serves on the planning committee for the Annual Statewide Trauma Informed Care Conference She ensures sessions are inclusive of issues relating to staff and individuals receiving services at their agency. The MS Band of Choctaw Indians has representation on the MS Mental Health Planning and Advisory Council. Clinicians from Choctaw Behavioral Health have participated in Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding the Chronic Stress (SPARCS) collaboratives funded by the Division of Children and Youth Services at DMH

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities

   To enable individuals with mental illness to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the 14 CMHCs offer an array of services These services include crisis services, which include Mobile Crisis Response Teams (MCeRTS), Psychosocial Rehabilitation Programs, Intensive Community Support Services, Peer Support Services, Supported Employment Services (offered by four CMHCs), and PACT Teams (offered by eight CMHCs) In addition, seven (7) CSUs are available throughout the state to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition Housing and support service needs are addressed through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	○ Yes ◉ No
b)	Mental Health	◉ Yes ○ No
c)	Rehabilitation services	◉ Yes ○ No
d)	Employment services	◉ Yes ○ No
e)	Housing services	○ Yes ○ No
f)	Educational Services	◉ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	◉ Yes ○ No
h)	Medical and dental services	○ Yes ◉ No
i)	Support services	◉ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	◉ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	◉ Yes ○ No

Please describe as needed (for example, best practices, service needs, concerns, etc)

Some of the best practices and/or evidence-based practices utilized by DMH certified providers in Mississippi's comprehensive community-based mental health service system include Mobile Crisis Response Teams (MCeRTs), Programs of Assertive Community Treatment Teams (PACT), Wraparound Facilitation, Wellness Recovery Action Plans (WRAP), Certified Peer Support Specialists, Permanent Supportive Housing, Supported Employment, NAVIGATE, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Mental Health First Aid In addition, providers certified by DMH to provide day treatment services to children and youth are required to use an evidence-based curriculum approved by DMH

Access to services, facilitation of additional Crisis Intervention Teams (CIT), continued efforts to increase access to affordable community-based housing options, improving transition of individuals from behavioral health centers back to their homes and communities, and making supported employment services more available are all needs and concerns of the adult mental health service system For the children and youth mental health service system, service provision for children with co-occurring disorders of SED and IDD, expansion of intensive home- and community-based services, continued collaboration with the two behavioral health managed care organizations to improve access to appropriate services, and efforts to decrease turnover and increase the skill-level of children's community mental health and other

providers of services for children/youth at the local level are needs and concerns.

3. Describe your state's case management services

Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. CSS are directed towards adults, children, adolescents and families and vary with respect to hours, type and intensity of services, depending on the changing needs of each individual The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. Community Support Services include identification of strengths which aid the individual in their recovery, therapeutic interventions that directly increase the acquisition of skills, psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual, crisis prevention, assistance in accessing needed services, relapse prevention and disease management strategies, and facilitation of the Individual Service Plan and/or Recovery Support Plan which includes the active involvement of the individual and the people identified as important in the person's life. Community Support Services must be provided by staff with at least a Bachelor's Degree in a mental health, intellectual/ developmental disabilities, or related field and at least a DMH Community Support Specialist Credential

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Mobile Crisis Response Teams (M-CeRTs) provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis The M-CeRTs target individuals experiencing a situation where the individual's behavioral health needs exceed the individual's resources to effectively handle the circumstances. Without mobile crisis intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. In FY 2016, the M-CeRTs made 22,768 contacts.

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. In FY 2016, 3,270 individuals were served in the Crisis Stabilization Units with an 89.2% diversion rate from inpatient care.

Mississippi currently has eight (8) Programs of Assertive Community Treatment Teams (PACT). In FY 2016, the PACT Teams served 249 individuals and had 85 new admissions.

Certified Peer Support Specialists provide services for individuals with mental illness in their communities with the goal of averting mental health crises by utilizing Personal Outcome Measures (POM), Wellness Recovery Action Plans (WRAP) and Community Asset Mapping. By utilizing this initiative, Mississippi decreases the need for inpatient psychiatric care and increases the number of individuals who attend follow-up appointments.

The Specialized Planning, Options to Transition Team (SPOTT) is a collaboration between DMH and the Arc of Mississippi to support people who have required treatment in inpatient programs on multiple occasions, or who are in crisis and need immediate assistance accessing services. SPOTT's goal is to provide people served through the public mental health system with access to more appropriate, peer supported, and community based choices for care SPOTT models person-centered processes to support people where they are, one person at a time

Making a Plan (MAP) Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement. In FY 2016, 55 MAP teams served 62 counties and 1,152 children and youth.

Narratve Question

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	121,542	
2.Children with SED	33,206	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI was utilized to calculate the estimate of prevalence of serious emotional disturbance among children and adolescents in Mississippi. According to URS Table 1, the estimated number of children, ages 9–17 years in Mississippi in 2015 is 368,956. Mississippi remains in the group of states with the highest poverty rate (25.7% age 5–17 in poverty, based on URS Table 1), therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2015 are as follows:

•Within the broad group (9–11%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 11–13% or from 40,585 – 47,984.

•Within the more severe group (5–7%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 7–9% or from 25,827 – 33,206.

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi. According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years and above is 5.4 % or 2,250,779 in 2015.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Narratve Question

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Mississippi has the Projects for Assistance in Transition from Homelessness (PATH) Program which provides services to eligible individuals who are experiencing homelessness and have serious mental illness and co-occurring substance use disorders. The focus has been on individuals who are literally homeless, living in places not meant for human habitation. Peer Support Specialists provide street outreach so workers continually interact with people. Peer Support Specialists rely on lived experience to help homeless individuals believe that getting out of bad situations is possible and that home, employment, and stability are obtainable. The PATH program provides the state with funds for flexible community-based services for persons with serious mental illnesses and co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. DMH provides funding to 4 CMHC's and 1 non-profit provider to operate PATH Programs.

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness Staff attends the MS United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings The DMH continues to receive technical assistance in the implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program in Mississippi as provided by SAMHSA The purpose of SOAR is to help states increase access to mainstream benefits for individuals who are homeless or at risk for homelessness through specialized training, technical assistance, and strategic planning for staff that provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process The DMH provides information and oversight regarding the online training. There is an online SOAR data collection system that SOAR processors in the state are encouraged to use to report the results of the SSI/SSDI applications that are submitted using SOAR.

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems

Planning Table 2 describes how Mississippi intends to expend the grant for FY 2017- FY 2019. Funding is allocated as required for Early Serious Mental Illness (10% Set Aside) and Administration. Of the remaining funds, 45% is allocated for community-based services for children and youth and 55% is allocated for community-based services for the adult population. Block Grant expenditures for adults include POS (Purchase of Service) Grants offering mental health services and providing indigent individuals with a source of payment based on Medicaid rate reimbursement. Intensive Community Support Grants provide individuals with intensive case management to avoid out of home placement and successful transitions from inpatient treatment back into their communities. Non-Community Mental Health Center Grants are awarded to NAMI-MS, Mental Health Association to operate the Drop-In Center, and the Arc of Mississippi for Personal Outcome Measures. Block Grant expenditures for children and youth include Juvenile Outreach Program Grants that provide mental health services to youth while in the detention centers, POS Grants for children providing a source of payment for mental health services in areas of higher commitment rates for children, and Community Service Provider Grants for respite, services for children from domestic violence situations experiencing trauma, early childhood intervention, and two CMHCs offering training to provide Wraparound Facilitation. The two NAVIGATE Programs are funded by the required 10% Set Aside to provide evidence-based treatment for youth and young adults experience First Episode Psychosis. The DMH plans to start at least 1 new NAVIGATE program.

The DMH Division of Professional Licensure and Certification (PLACE) is responsible for developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH. The network of programs fitting this description is collectively referred to as Mississippi's "state mental health system." DMH currently offers the following credentialing programs: Certified Mental Health Therapist (CMHT), Certified Intellectual/Developmental Disabilities Therapist (CIDDT), Certified Addictions Therapist (CAT), Certified Community Support Specialist (CCSS), and Licensed DMH Administrator (LA). Peer Support Specialists are credentialed by successfully completing the Certified Community Support Specialists Program. Two designations exists for Certified Peer Support Specialists: Certified Peer Support Specialist-Adult (CPSS - Adult) and Certified Peer Support Specialist-Parent/Caregiver (CPSS-Parent/Caregiver). These programs are not funded by MHBG funds.

The Department of Mental Health provides web-based training through Relias Learning for registered DMH certified providers. Relias is a customized learning management system and staff development tool that offers evidenced – based practices training. The Relias Learning training website tracks staff training and eliminates the need for extensive travel to obtain training.

In addition, training and technical assistance are provided by DMH staff to certified DMH providers and the general public as requested on topics related to mental illness and substance use disorders. Topics such as suicide awareness and prevention, Mental Health First Aid, and A.S.I.S.T. are provided to other state agencies, school districts, community colleges and universities, and law enforcement officers and other first responders. Furthermore, professional mental health staff from the community mental health centers (CMHC) provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. Officers from around the state can attend CIT training in Meridian at no cost as a result of a contract between DMH and the Lauderdale County Sheriff's Department.

DMH staff provides trainings in the northern, central, and southern portions of the state to Certified Peer Support Specialists (Adult and Parent/Caregiver). Ethics, confidentiality, and documentation are a few of the topics reviewed in these trainings. National consultants and trainers are utilized as needed to train certified providers on evidenced-based practices and services provided through grants obtained by the Department of Mental Health.

Nationally Certified Wraparound Facilitation Coaches with the Mississippi Wraparound Institute (MWI) at the University of Southern Mississippi provide training, support, and technical assistance to potential and certified providers of Wraparound Facilitation in our state.

The Division of Children and Youth Services continues to provide trauma-informed trainings to community and state partners including family members and caregivers.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? (•) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

The Mississippi Board of Mental Health's DMH Strategic Plan is an essential tool that drives the transformation of the mental health system into one that is outcome-oriented and community-based. The Plan serves as a map for guiding the direction the DMH is taking to meet the goals and changing demands of mental health care in Mississippi The Strategic Plan is continually streamlined with both mid-year and end-of the year reports recording progress made in achieving the goals and objectives of the Plan. The Plan is revised annually with input from consumers, advocates, stakeholders, and outcome leaders. The current DMH Strategic Plan for FY 2018 – FY 2020, as well as prior Strategic Plans, highlights, and mid and end of year reports since 2010, can be found and reviewed at http://www.dmh ms.gov/resources/

On an annual basis, the Mississippi Department of Mental Health (MDMH) conducts a consumer satisfaction survey, administering questionnaires to a representative sample of both adult and youth consumers The Survey Research Laboratory (SRL) at Mississippi State University is commissioned by DMH to conduct the agency's Consumer Satisfaction Survey for both adult and youth consumers of mental health services Separate surveys are designed and administered to adult mental health consumers and parents/caregivers of youth mental health consumers. Both questionnaires are designed primarily with close-ended, multiple-choice questions, but each questionnaire also allows participants the option of providing responses to several open-ended questions. Questionnaires are mailed to mental health facilities in each of the 14 mental health regions across the state of Mississippi Each questionnaire takes approximately 15-20 minutes to complete, after which the survey participants are instructed to place the questionnaire in a sealed envelope for return delivery to the SRL at Mississippi State University The sample size for each region is determined by calculating the number of consumers served in a given region during an average two-week period based on service records from the previous year In addition, regional managers are asked to distribute questionnaires to all satellite facilities within their region, proportionate to the number of consumers that each satellite facility serves.

The Office of Incident Management is responsible for both DMH's disaster response and preparedness activities and managing the serious incident reporting system utilized by the DMH certified providers. In responding to statewide emergencies, the DMH's Director of the Office of Incident Management serves as the liaison between the Department and the MS Emergency Management Agency. In the State's Comprehensive Emergency Management Plan, the DMH serves as a support agency for ESF 6, ESF 8 and ESF 15. The DMH maintains a statewide emergency response plan and continuity of operations plan The DMH requires all certified providers to maintain both disaster/emergency response plans and continuity of operations plans specific to their local sites and emergency management/disaster response structures at the local level

The DMH tracks and responds to serious or critical incidents. The DMH defined serious incidents which include categories such as: suspected abuse, neglect or exploitation, injury occurring at a program location, death, suicide attempt at a program location, elopement from a program, medication errors, etc. Certified providers are responsible for reporting serious incidents to the Office of Incident Management within 24 hours The Office of Incident Management triages all reports, assigns a category of incident, and level for DMH response/follow-up The Office of Incident Management conducts on-site follow up on serious incidents assigned a Level III. The Office of Incident Management also utilizes a CQI approach to its follow up process As issues are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues. Providers develop and implement corrective action to prevent future occurrence

The Office of Consumer Support is responsible for operating the state's grievance system. Individuals may report a grievance regarding the care of someone receiving services through the public mental health system All certified programs are responsible for posting DMH's 1-877 line in the program areas and incorporating the Office of Consumer Support into their local level grievance procedures that are shared with all people receiving services. Much like the serious incident management system, the Office of Consumer Support triages all grievances received, assigns a category of grievance and a level for DMH response/follow-

up. The DMH's target for resolution of grievances is 30 days from the date filed.

Please indicate areas of technical assistance needed related to this section.

- **Footnotes:**

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
61 *Ibid*

Please respond to the following items

1.	Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?	(•) Yes ( ) No
3.	Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
4.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	( ) Yes (•) No

5. Does the state have any activities related to this section that you would like to highlight.

As required by the Department of Mental Health's Operational Standards, mental health providers certified by the Department of Mental Health have integrated trauma screening practices into the initial intake assessment process for individuals receiving services. All new cases must have a Trauma Screening with documentation in the case records of individuals receiving services

The Department of Mental Health, Division of Children and Youth Services continues to provide trauma-informed trainings to community and state partners including family members and caregivers. Since 2006, providers of children and youth mental health services in Mississippi have been trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT). To date, there are 380 TF-CBT Therapists, 110 SPARCS Therapists and 15 CPC-TFC Therapists.

Mississippi also has (3) three National Child Traumatic Stress Network Sites. They are Catholic Charities, Inc., Region 13/Gulf Coast Mental Health Center, and Wilson-Sigrest, LLC. In direct response to the needs from Hurricane Katrina, Mississippi was the first State to have a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) state level Learning Collaborative coming out of National Child Traumatic Stress Network (NCTSN).

In 2014, the Department of Mental Health held its first state-wide Trauma Conference. In addition to cross system training on Trauma- Informed Care, DMH continues to partner with several state and local agencies to host the annual Mississippi Trauma Informed Care Conference. The 2017 Trauma Informed Care Conference will be held September 27-29, 2017. These annual conferences have brought together more than 600 participants each year. The sessions are inclusive and appropriate for a diverse audience representing mental health and substance abuse professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?	(•) Yes ( ) No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	(•) Yes ( ) No
3.	Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?	(•) Yes ( ) No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?	( ) Yes (•) No

5. Does the state have any activities related to this section that you would like to highlight?

In September, 2016, Mississippi was awarded a $647,461 federal grant aimed at reducing recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. The Department of Corrections (MDOC) and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders for 36 months, beginning October 1, 2017. Region 9, Hinds Behavioral Health Services (HBHS), will be the provider for this pilot project.

Program eligibility criteria includes offenders with co-occurring mental health and substance use disorders who score medium-to-high risk for recidivism and are returning to Hinds County for community supervision. Pre-release services include a full array of mental health, substance use, and trauma assessments to determine individuals' needs to inform integrated risk-based treatment and reentry plans. Post-release services are centered around a clinical intensive outpatient program that integrates a correctional curriculum developed by the National Institute of Corrections "Thinking for a Change". MDOC Probation/Parole staff will deliver the "Thinking for a Change" sessions during IOP group at Hinds Behavioral. This allows offenders to complete their supervisory reporting without making a special trip to the probation/parole office. This model also creates an interdisciplinary team between

HBHS and MDOC to offer full comprehensive support to offenders In addition to IOP, program participants will have access to all of the services offered at HBHS including medication management, crisis intervention, and recovery support services. Current plans are to serve 90 individuals during the three-year pilot program in order to develop a program model that can be replicated statewide with the receipt of additional federal grant funding

On April 12 and 13, 2017, a total of 22 individuals participated in the "How Being Trauma-Informed Improves Criminal Justice System Responses" Train-the-Trainer (TTT) Event Participants included staff from CMHCs, MDOC and the Attorney General's office. The training focused on increasing understanding of trauma, creating an awareness of the impact of trauma on behavior, and developing trauma-informed responses. Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals, and thereby increase safety for all, decrease recidivism, and promote and support recovery of justice-involved women and men with serious mental illness Partnerships across systems can also help to link individuals to trauma-informed services and treatment for trauma.

The week of June 19-23 2017, 9 MDOC training and mental health/medical staff completed the train-the-trainer event to become certified trainers of MHFA-Public Safety These staff members will disseminate this 8-hour training each month during mandatory MDOC institutional officer and probation/parole agent refresher training courses as well as throughout the MDOC organization (administration, support staff, offender services and MS CORP stakeholder group.)

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers. The officers receive approved continuing education credits from DPS. Additionally, The DMH has entered into a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost to the other law enforcement agencies. The DMH has mailed letters, brochures and a video promoting the CIT training opportunity to all 82 sheriff's departments and to 49 of the major police departments around the state DMH and DPS recognize officers who have completed CIT training by awarding them a certificate from the DMH and DPS signed by Ms Diana Mikula and Commissioner Fisher, and they get 40 hours of CEs from DPS In addition to the Lauderdale County CIT program, Region XII, Pine Belt Mental Health, has helped established a CIT program in Jones County, with the Sheriff's Department, Laurel PD, Ellisville PD, and Westway CSU They are in the initial phases of establishing a CIT program in Forrest County, with the Sheriff's Department, Hattiesburg PD, Petal PD, and Forrest General Hospital Region IV Mental Health has helped establish a CIT program in DeSoto County, with the Sheriff's Dept., Southaven PD, Horn Lake PD, Hernando PD, Olive Branch PD, Walls PD, and Baptist Memorial Hospital

Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need. The DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes ○ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ○ Yes ○ No
3. Does the state purchase any of the following medication with block grant funds? ○ Yes ○ No
   - a) ☐ Methadone
   - b) ☐ Buprenophine, Buprenorphine/naloxone
   - c) ☐ Disulfiram
   - d) ☐ Acamprosate
   - e) ☐ Naltrexone (oral, IM)
   - f) ☐ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ○ Yes ○ No
5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

: This section is addressed in Mississippi's SABG application submission.

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427 Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009 http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☐ Family Engagement
   - d) ☐ Safety Planning
   - e) ☐ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☑ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☑ Crisis Residential/Respite
   - d) ☑ Crisis Intervention Team/Law Enforcement
   - e) ☑ Mobile Crisis Outreach
   - f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☑ WRAP Post-Crisis
   - b) ☑ Peer Support/Peer Bridgers
   - c) ☑ Follow-up Outreach and Support
   - d) ☑ Family-to-Family Engagement

e) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☑ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances Crisis Stabilization Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content varies based on each individual's needs but includes close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. The DMH funds seven, 16-bed CSUs and partially funds one, 24-bed CSU throughout the state.

Additionally, DMH provides funding to the 14 CMHCs to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC's regions The calls received by the crisis phone line are triaged for severity. Some calls are handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team Each CMHC region is required to provide mobile response services in every county they serve The mobile crisis response teams (MCeRTS) must be able to respond within one hour in an urban area and within two hours in a rural area The mobile crisis response teams are required to have a Master's level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity Additionally, if the mobile crisis response team must respond in an area that may not be safe,law enforcement accompanies them. A strong working relationship with law enforcement is required through the grant funding The mobile crisis response team triages during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with psychiatric care available The mobile crisis response team develops working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The "warm-handoff" model is used to facilitate services for the person in crisis with the next provider Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter "regular" services with the CMHC or other provider All individuals receiving services at a CMHC who have recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMHC staff and any significant others the individual wants involved As part of the crisis response system, the CMHC's develop a multi-disciplinary assessment and planning team (MAP Team) made up of all the agencies that work with the most well-known individuals in the community The MAP teams usually consists of mental health, health, human services, police department, sheriff's office, chancery clerk, faith based ministries, housing, etc., to develop a plan for the individuals in their community which consume the most time from all these agencies. The MAP Teams work together to find an alternative to continually committing the same individuals over and over to one of the state behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff's Office to develop Crisis Intervention Teams (CIT)) across the state The Lauderdale Sheriff's Office is a training site for officers from anywhere in the state to come for the 40-hour training required to be a CIT officer The local CMHC is fully involved in the curriculum development and presentation The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (•) Yes ( ) No

   b) Required peer accreditation or certification? (•) Yes ( ) No

   c) Block grant funding of recovery support services ( ) Yes (•) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   Yes. Recovery is based on the involvement of consumers/peers and their family members. Efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health system include:

   Planning Services – Consumers and family members have an opportunity for meaningful participation on planning councils, task forces and work groups on a state, local, and national level.

   Delivery of Services – Consumers and family members are employed as Certified Peer Support Specialists

   Evaluation of Services – Consumers and family members have an opportunity to participate on personal outcome measure interviews using the Council on Quality of Life Personal Outcome Measures. The personal outcome measure interviews provide an opportunity for consumers and family members, through a guided conversation, to evaluate quality of life Consumers and Family members, on a local level are involved in consumer and family satisfaction surveys.

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state

   The Recovery-Oriented System of Care model is designed to support individuals seeking to overcome mental health disorders and substance use disorders across their lifespan. The service components of the Recovery-Oriented System of Care model include: consumer support services, outpatient services, crisis response services, community living options, identification and outreach, psychosocial rehabilitation services, supported employment, family/consumer education and support, inpatient services, protection and advocacy, and other support services Services for individuals with a co-occurring disorder of serious mental illness and substance use are also included in the system of community-based care

   The Mississippi Department of Mental Health has adopted the philosophy that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented as highlighted in the Mississippi Board of Mental Health and Mississippi Department of Mental Health Strategic Plan. The FY18 – FY19 DMH Strategic Plan includes objectives focused on utilizing peers and family members to provide varying supports to assist individuals in regaining control of their lives and their recovery progress. These objectives are met through the Certified Peer Support Specialist Program, recovery-oriented system of care trainings, Personal Outcome Measures (POM), and other activities. The Plan also includes strategies to increase the use of Wellness Recovery Action Plans (WRAP) DMH administers the Certified Peer Support Specialist Program for people who have lived experience of mental illness and/or substance use disorder and/or family members who want to provide peer recovery services to others. In addition, the Think Recovery awareness campaign is helping to move the public mental health system towards a recovery-oriented system of care.

   The DMH sponsors meetings with peer support specialists and certified peer support specialists to discuss the role of peer support and barriers to provision of peer support services within the behavioral health service system The DMH also sponsors various councils, task forces, work groups and committees as an avenue to address issues and needs regarding the behavioral health service system.

   Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning; shared decision making; and direct their ongoing care through the Breakthrough Series The DMH provides trainings to peer specialists and is working with advocacy groups, consumers and family members to develop a system that affords consumers and family members the opportunity for meaningful participation in treatment, service delivery system, etc

Certified Peer Support Specialist Program

The DMH's Peer Support Specialist Program began in 2012 Currently, DMH certified providers have employed 149 Peer Support Specialists Certification is required for Peer Support Specialists in Mississippi, which leads directly to employment opportunities. Two designations exist for CPSSs – Certified Peer Support Specialist – Adult and Certified Peer Support Specialist – Parent/Caregiver All Certified Peer Support Specialists (CPSS) are supervised by a CPSS who has completed the State Certified Peer Support Specialist Supervisor Training. This training is provided at least twice a year at no expense to participants CPSSs in Mississippi are employed in a variety of settings including crisis services, housing and employment programs, homeless programs, drop-in centers, psychosocial rehabilitation programs, and inpatient services. The state financially supports an annual Certified Peer Support Summit which provides CPPSs an opportunity to stay connected to each other, share concerns, learn from one another's experiences, and stay informed about upcoming events and activities. DMH also supported the development of and continues to support the operation of the Association of Mississippi Peer Support Specialists (AMPS)

CPSSs are trained with the DMH Certification Team to conduct certification visits of DMH certified providers. On the certification visits, CPSSs conduct interviews with CPSSs, CPPS supervisors and other CMHC staff members, review Recovery Support Plans, and supporting documentation to evaluate the progress of providers toward a person centered, recovery-oriented system of care and the integration of peer support services into the behavioral health system Additionally, DMH staff in conjunction with CPSSs conduct training on Recovery-Oriented Assessment, Individual Service Planning and Progress Note documentation, Language of Recovery, Environment of Recovery, and Share Your Story to DMH Certified Providers CPSSs also participate in an interview process and Train the Trainer to participate in Recovery-Oriented System of Care technical assistance and training opportunities

Personal Outcome Measures (POM) are a powerful tool for evaluating personal quality of life and the degree to which providers individualize supports to facilitate outcomes. The results from POM interviews give a voice to people receiving services All CMHCs in the state participate in the POM interview process. The data is compiled and utilized to strengthen Mississippi's efforts to transform to a person centered, recovery-oriented system of care

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state

Recovery Support Services for individuals with substance use disorders are non-clinical services that are offered before, during and after any services that assist individuals and families working towards recovery from substance use disorders They incorporate a full range of social, legal, and other resources that facilitate recovery and wellness to reduce or eliminate environmental or personal barriers to recovery RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families. This service requires a twelve (12) month step down approach. Emphasis is placed on the "critical time" of the first six (6) months of service. In the first 3 months of treatment, requirements include face to face contact for a minimum of one hour weekly, community involvement such as 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery, weekly random drug screes, and weekly family contact . The subsequent three (3) months include face to face contact for a minimum of one hour every other week, continued community involvement, monthly random drug screens; and family contact as needed. For the remaining 6 months, Recovery Support staff must make at least one (1) attempt to contact each member per month Group or individual sessions are acceptable as contacts. Recovery Support staff must maintain on site a comprehensive file of existing community resources. Recovery Support Staff must develop an annual plan for conducting community outreach activities that must include: each county in their catchment area, an emphasis on alcohol and other drug treatment and prevention services offered by their organization, a minimum of twelve (12) community activities per year and cannot be limited to exhibits or booths at community events, and identification of targeted community health providers, areas or populations such as workplaces of young adults, physicians, drug courts, etc

5. Does the state have any activities that it would like to highlight?

The Mental Health Association of South Mississippi Opal Smith Drop-In Center offers a peer-run day program for adults with mental illness and people with disabilities. Instead of being alone, people fill their day with arts, crafts and games, making friends, and gaining confidence At the Center, peers assist individuals in exploring personal interests in a safe, non-judgmental way and help them learn to become more independent in a recovery-oriented environment. The Center also develops Wellness Recovery Action Plan (WRAP) with individuals who come to the Center

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided	(•) Yes ( ) No
home and community based services	(•) Yes ( ) No
peer support services.	(•) Yes ( ) No
employment services	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   The CHOICE program described below, the eight (8) Programs of Assertive Community Treatment (PACT) teams, and Personal Outcome Measures (POM) interviews are addressing the ADA community mandate required by the Olmstead Decision in our state.

   Does the state have any activities related to this section that you would like to highlight?

   In June 2013, the Department of Mental Health facilitated a SAMHSA-sponsored Olmstead Policy Academy to help Mississippi develop action plans to increase community integration for people with behavioral health issues. With the help of a lead facilitator assigned to us by SAMHSA, a Mississippi team spent several months developing a one-year action plan with goals and strategies to help us promote community integration through improved housing, employment, and recovery support opportunities for people with behavioral health disorders in Mississippi. The team was made up of approximately 30 individuals representing service providers, policy makers, and stakeholders in the targeted areas of housing, employment, and recovery support. The Olmstead Policy Academy Strategic Plan that resulted from the efforts of the Policy Academy members identified goals, strategies, and activities for each of the three critical areas included in the plan that ultimately led to the development in 2014 of a more comprehensive, targeted state plan for statewide systematic approach to addressing the requirements of Olmstead and Title II of the ADA.

   Multiple agencies, including development authorities, housing corporations, regional housing authorities, state departments, federally funded contractors and local contracted providers have a role in providing housing and supportive services for individuals with disabilities and life challenges in the State of Mississippi. In 2014, the State of Mississippi, through an appropriation to the Mississippi Department of Mental Health (DMH), engaged in the development at a statewide integrated, supportive housing (ISH) strategy for people with mental illness, intellectual and developmental disabilities (IDD), addictive disease, Veterans and other high need populations in Mississippi served by agencies such as the Department of Human Services (DHS), Department of Health (DOH), and the Department of Corrections (DOC). ISH refers to safe, secure and affordable housing,

where tenancy is not time-limited as long as the resident pays the rent and honors the conditions of the lease. Individualized and flexible support services are available to residents based upon their choices and needs.

The Creating Housing Options in Communities for Everyone (CHOICE) program, funded by the State of Mississippi, is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and the 14 community mental health centers. The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance, with supportive mental health services through Integrated Supportive Housing. The goals of the CHOICE program are to assist individuals with mental illness or disabilities with permanent housing, peer services and community-based services, make 2,500 rental units available for the target population within five (5) years, connect CHOICE participants to available resources through an integrated referral process, and help CHOICE participants obtain and retain permanent housing in the community. CHOICE participants are assisted by priority. Priority 1 individuals are those that are being discharged from a state psychiatric hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities after a stay of more than ninety (90) days. Priority 2 individuals are those who have been discharged from a state psychiatric hospital within the last two (2) years and have had multiple hospital visits within the last year due to mental illness, are known to the mental health or state housing agency to have been arrested or incarcerated in the last year due to conduct related to mental illness or who are known to have been homeless for one (1) full year or have had four (4) episodes of homelessness in the last three (3) years. Priority 3 individuals are those who lack a fixed, regular, and adequate nighttime residence and/or who are exiting from an institution where they resided for ninety (90) days or less and who resided in emergency shelters or places not meant for human habitation immediately before entering that situation. There have been approximately 130 individuals housed through the CHOICE program since March 2016.

During Mississippi's Legislative session that ended in April 2015, a bill was passed and signed by the Governor to fund a State Bridge Subsidy voucher targeted to individuals identified in Olmstead and included in a joint agreement letter dated August 29, 2014, between the US Department of Justice and the Attorney General of Mississippi. Implementation of the state-funded bridge subsidy program is administered by the MS Home Corporation (MHC) which is Mississippi's Housing Finance Agency in direct partnership with the Department of Mental Health and with active participation by the state's Community Mental Health Centers (CMHC)

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[66]Centers for Disease Control and Prevention, (2013) Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2)

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nltt-ts/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? (•) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? (•) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? (•) Yes ( ) No

   b) Juvenile justice? (•) Yes ( ) No

   c) Education? (•) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes (•) No

   b) Costs? ( ) Yes (•) No

   c) Outcomes for children and youth services? (•) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (•) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? (•) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? (•) Yes ( ) No

   b) for youth in foster care? (•) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   DMH was recently awarded a Cooperative Agreement to begin October 1, 2017, which will focus on youth who are involved with the child welfare and/or juvenile justice systems, referred to as "crossover youth" The Crossover XPand SOC project will expand current and graduated System of Care (SOC) programs in two jurisdictions served by Region 12/Pine Belt Mental Healthcare Resources and Region 10/Weems Community Mental Health by prioritizing crossover youth and their families and those at risk of becoming crossover youth or underserved children and youth who are involved in the child welfare/advocacy system and/or the juvenile justice system The priority children and youth will have a diagnosed serious emotional disorder (SED), co-occurring disorder (COD), or first episode of psychosis (FEP), be ages 3 -21, reside in Forrest, Jones, Lauderdale, or Marion Counties in Mississippi, and be involved with child protection services and/or juvenile justice, or be at risk for involvement.

   The goals of Crossover XPand SOC are: 1) to expand Mississippi's SOC by targeting at risk and crossover youth (ages 3-21) with SED/COD/FEP and their families and expanding integrated care with evidence-based interventions; 2) to increase awareness of, and community commitment to, the mental health issues of at risk and crossover youth; 3) to improve organizational and systemic capacity to serve at risk and crossover youth with SED/COD/FEP across five levels of care; 4) to expand youth and family roles as full and equal partners within an integrated system of care; and 5) to use continuous quality improvement to drive and sustain effective service delivery for replication. Crossover XPand SOC will annually engage a minimum of 100 at risk or crossover youth, for a total of 400 youth over the entire project period. Other objectives include improving time to engage youth by integrating

services at strategic intercept points, expanding access to care, and creating a skilled trauma-focused workforce

Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need The DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state Youth from communities in which there is no local MAP team with funding have priority

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (•) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state

DMH established the Mississippi State Suicide Prevention Plan Workgroup in April 2016 to finalize the state's efforts in developing a formal plan to help combat a public health issue that affects people of all ages, races, and gender – suicide More than 26 people serve on the workgroup including state agencies, family members, non-profits, schools, and others The workgroup communicates regularly and meets quarterly Mississippi's State Suicide Prevention Plan was released in September 2016. The three -year plan was divided into four main sections - Assessment, Capacity, Goals and Objectives, and Stories. The Assessment portion of the plan gathered data that addressed demographic information about our state and trends that have occurred over the years in the mental health field The Capacity section examined current state resources that are available to address this public health issue at the current time The Goals and Objectives were data-driven targets that point to the progress we hope to make with this plan. The Stories were included to help shatter the silence around suicide – thoughts of taking your own life are not thoughts that someone should keep inside The plan can be reviewed at http://www.dmh.ms gov/wp-content/uploads/2016/09/Suicide-Prevention-Plan-Final-1.pdf

Over the last fiscal year, the Mississippi Department of Mental Health and partners across the state have diligently worked to make progress with the objectives in the plan A report highlighting the state's efforts since September 2016 – June 2017 will be available online in August and includes the following information In FY17, there were 258 presentations reaching 10,589 participants These participants received suicide prevention information through a variety of trainings including ASIST, QPR, Mental Health First Aid, Shatter the Silence, and others. Participants included: school nurses, law enforcement, students, healthcare employees, parents, and others. Information included risk factors, protective factors, warning signs, and referral information In addition, DMH and DREAM of Hattiesburg partnered with MDE's Office of Healthy Schools and trained 289 school nurses in six 1-hour presentations on suicide awareness and intervention DMH also partnered with the Rankin County School District and facilitated 13 suicide prevention trainings to all school teachers, coaches and administrators In February, DMH partnered with DOE to send a letter to all school nurses and counselors offering Shatter the Silence materials (cards and posters) and presentations. Suicide prevention information is presented to students statewide through Shatter the Silence presentations and the I Got U program During FY17, 6,964 students including middle school, high school, college, and nursing students were reached through these campaigns. DMH and MS Department of Education (MDE) met in June to discuss HB 263 MDE's Office of Healthy Schools will require local school districts conduct the in-service training on suicide prevention for all school district employees during the 2017-2018 school year. This will be verified through the monitor visit process Questions will be added to the monitoring tool if needed In addition, a checklist will be provided to all school districts to ensure they are aware of the requirements.

DMH provided a Model School District Policy on Suicide Prevention developed by The Trevor Project, American School Counselor Association, American Foundation for Suicide Prevention, and National Association of School Psychologists The workgroup is considering using this as Mississippi's model policy for school districts to use as a template to assist districts in adopting their own specific policies. DMH is exploring the use of two online professional development series as the training required for all school district employees This would be at no cost and would not require travel There is also a certificate that can be printed for proof of completion.

DMH met with the Mississippi National Guard in April to discuss ways to expand Operation Resiliency and suicide prevention efforts DMH provided 150 copies of the Operation Resiliency materials. DMH will offer Mental Health First Aid training and QPR training to the National Guard in FY18 DMH also sent a letter and 50 copies of the Operation Resiliency information to all VA Centers in Mississippi

The National Suicide Prevention Lifeline is currently included on Shatter the Silence materials (cards, billboards, posters, presentations), Operation Resiliency materials, DMH's website and Facebook page, and other outreach. This information was included on Shatter the Silence billboards across the state during FY17. In FY18, DMH will work with state agencies and other providers to include the contact information on their outreach tools. In addition, DMH and the Suicide Prevention Workgroup are hosting the state's 1st Suicide Prevention Symposium on September 19, 2017. This is an effort to engage other health, mental health, state agencies, and substance use prevention partners. While we are proud of the strides have been made in developing awareness and increasing knowledge about suicide in recent years, there is still significant progress to be made. DMH and its partners will continue to make suicide prevention a priority.

3. Have you incorporated any strategies supportive of Zero Suicide? ○ Yes ◉ No

4. Do you have any initiatives focused on improving care transitions for sulcidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

The Mississippi's State Suicide Prevention Plan was released in September 2016 and now includes all populations and objectives target youth, adults, older adults, military, and other populations.

Does the state have any activities related to this section that you would like to highlight?

The promotion of "Zero Suicides" and research for how other states are utilizing it will be addressed in FY18.

Regarding initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments, DMH met with the Mississippi Hospital Association to discuss outreach activities with emergency rooms/hospitals. DMH will submit an article in the Fall edition of Mississippi Hospitals educating readers about suicide prevention and how to link patients to providers. DMH will also present on this topic at the statewide MHA Conference in September. This initiative will be further developed in FY18

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (•) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (•) No

   If yes, with whom?

   DMH is partnering with two of the Mississippi Division of Medicaid's managed care programs, Cenpatico (Magnolia) and Optum (UnitedHealthcare), which are included in the Mississippi Coordinated Access Network (MississippiCAN). Representatives from these programs participate on the State Level Case Review Team for children and youth and attend the MS Mental Health Planning and Advisory Council Meetings. MississippiCAN is a statewide coordinated care program designed to improve beneficiary access to needed medical services, improve quality of care, and improve program efficiencies as well as cost predictability DMH also participated in the development of and continues to support and partner with the Association of Mississippi Peer Support Specialists (AMPSS).

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act

   In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care Representatives from various State agencies participate on the Mississippi State Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for Community -based Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) program, one of 10 PRTF Demonstration Projects approved that year by the federal Centers for Medicare and Medicaid Services (CMS) The Division of Medicaid called the program Mississippi Youth Programs Around the Clock (MYPAC). Home- and community-based alternatives to residential treatment or institutionalization have been and are being developed to continue implementation of strong infrastructure, particularly for the one to three percent of the population with the most intensive needs targeted This service includes 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and Wraparound teams who develop individual service plans Successful outcomes include shorter lengths of stay at PRTFs, diversion from PRTF admissions, more coordinated treatment for youth with Serious Emotional Disturbance (SED), a reduction in the overall cost to the State, and an improved system of care for youth with SED

In February 2011, the Mississippi Division of Medicaid was one of 13 states awarded the Money Follows the Person demonstration grant, which ends at the end of September 2017. The allocation awarded was $37 million over six years. The Department of Mental Health has worked closely with the Division of Medicaid to assist in this effort. The goal of this grant was to increase the ratio of community-based service spending compared to institutional spending over the course of the six-year grant. Cost savings achieved by transitioning people out of institutions were directed into community-based services to help eliminate barriers that prevented or restricted flexible use of Medicaid funds and enabled individuals to receive long-term care in the setting of their choice

The DMH has an agreement with the MS Department of Public Safety (DPS) Professional mental health staff from the community mental health centers (CMHC) provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers The officers receive approved continuing education credits from DPS The DMH has a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost. The Department of Corrections and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders for 36 months, beginning October 1, 2017.

Programs that provide services for children with mental health needs are available and accessible in the regular education setting as well as the special education arena. In Mississippi, there are fourteen (14) Community Mental Health Centers (CMHC), with each location being responsible for provision of services to local school districts certified by the Mississippi Department of Education via interagency agreements. All 14 CMHCs are required to have interagency agreements with each local school district in their region. As a result of this agreement, the number of students receiving services for assistance with emotional and behavioral disabilities while attending general and/or special education was approximately 27,100 in FY 2016. Statewide initiatives such as those on suicide prevention, bullying, and cybercrimes (sexting) have also played a large role in providing assistance to all students to prevent inpatient stays and residential institutionalization

In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate Mississippi Department of Education accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning Section 504 Teacher Units are also approved through the Department of Education to local school districts for community residential programs for adolescents with substance use problems and other areas under Section 504 criteria. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems Children with serious emotional disturbance who meet eligibility criteria for a disability in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state A free appropriate public education (FAPE) must be available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP). After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment

IDEA 2004 defines emotional disturbance as a condition in which a child exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: inability to learn that cannot be explained by intellectual, sensory or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behavior or feelings under normal circumstances; general pervasive mood of unhappiness or depression; and/or tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia and does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance The Division of Parent Outreach within the Mississippi Department of Education, Office of Special Education (OSE), provides information and training in areas of identified need to parents, students, and community organizations This division works to build collaborative relationships with parents and organizations interested in services to children with disabilities. This division also provides the following: training regarding parental rights and services

under IDEA 2004; development and distribution of materials for parents; handling of parent complaints, mediation, Resolution Sessions, and due process hearings; and conducting meetings with stakeholders The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses counseling, psychological services and the needs assessment. One of the eight components of the Center for Disease Control and Prevention's (CDC) coordinated school health is counseling and psychological services In accordance with this component, Mississippi public schools are required to establish a local school wellness policy.

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness Staff attends the Mississippi United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings.

Does the state have any activities related to this section that you would like to highlight?

DMH is always open to and welcomes opportunities to partner with other agencies As seen throughout the MHBG Block Grant application, DMH currently partners with the Division of Medicaid (Office of the Governor), Mississippi Department of Human Services, Mississippi Child Protection Services, Mississippi Department of Health, Mississippi Department of Education, Mississippi Department of Corrections, Disability Rights, Mississippi National Guard, Mississippi Attorney General's Office, Mississippi Board of Pharmacy, Mississippi Bureau of Narcotics, Mississippi Public Health Institute, University of Mississippi Medical Center, Mississippi Department of Public Safety, the ARC of Mississippi, Southern Christian Services for Children and Youth, Vicksburg Family Development Center, Families As Allies for Children's Mental Health, Inc., Canopy, Mental Health Association of the Gulf Coast, Gulf Coast Women's Center for Non-Violence, NAMI Mississippi, Mississippi United to End Homelessness (MUTEH), Mississippi Home Corporation, Cenpatico, Optum, the Association of Mississippi Peer Support Specialists, and the 14 CMHCs and all other DMH certified providers of mental health services. DMH also works closely with the institutions of higher learning in our state including the University of Mississippi, Mississippi State University, Jackson State University, Belhaven University, Alcorn State University, and the University of Southern Mississippi

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] **http://beta.samhsa.gov/grants/block-grants/resources**

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The Bureau of Alcohol and Drug Services at DMH is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems. The overall goal of the state's alcohol and drug service system is to provide a continuum of community-based primary and transitional residential treatment, inpatient and recovery support services

   The Councils for Alcohol and Drug Services and Mental Health are not combined at this time However, two representatives from the Alcohol and Drug Services Advisory Council also serve on the Mental Health Planning and Advisory Council. The Bureau of Community Services and the Bureau of Alcohol and Drug Services work together in developing the State Plan

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into t ○ Yes ◉ No

2. Is the membership representative of the service area population (e.g ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? ○ Yes ◉ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED

   The members of the Mississippi State Mental Health Planning and Advisory Council make comments to and approve the MHBG application/FY 2018-2019 Mississippi State Plan for Community Mental Health Services Council members serve as advocates for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses through promotion and assistance in planning and developing comprehensive mental health treatment, support, and rehabilitation services for these individuals The Council also monitors, reviews, evaluates, and advises the allocation and adequacy of mental health services within the state

   The Planning Council members and committees are asked to identify topics they want information on following each Planning Council meeting. The topics addressed at each meeting are based on the Council members' requests The Planning Council met: February 2, 2017, May 11, 2017, and August 10, 2017 The next meeting is scheduled for November 2, 2017 At each meeting, the Council is consistently informed of the status of the Department of Mental Health's budget

   Does the state have any activities related to this section that you would like to highlight?

The response to 1.b : Substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities is addressed in the SABG application submission for Mississippi. However, two representatives from the Alcohol and Drug Services Advisory Council also serve on the Mental Health Planning and Advisory Council.

The Council members receive information on the application instructions for the draft and final report provided by SAMHSA. The process to make a Draft Plan available for review by the Council and the public has proceeded along timelines to allow sufficient time for public review and comment in compliance with the federal submission timeline.

The Council received reports on the major initiatives planned for FY 2018-2019 at the August meeting. The State Plan Draft was presented to the Council at the August meeting. The comment period for the State Plan Draft was August 7, 2017, through August 28, 2017. The Council had the opportunity for review of the FY 2018-2019 State Plan Draft during that time

Public notices of the availability of the Draft Plan for public review and comment were made available at the 14 regional community mental health centers across the state, the East MS State Hospital in Meridian, the MS State Hospital in Whitfield, the North MS State Hospital in Tupelo, the South MS State Hospital in Purvis, the Central MS Residential Center in Newton, the five regional centers for persons with intellectual developmental disabilities, the Specialized Treatment Facility and the Mississippi Adolescent Center operated by the Department of Mental Health and on the MS Department of Mental Health's website. A Draft Plan was sent directly to the directors of the community mental health centers and the Department of Mental Health facilities asking them to make the Plan available to their employees and other interested individuals in their area of the state. The Draft Plan was also sent to all members of the MS Planning and Advisory Council.

In addition to those entities listed in the public notice, the Draft Plan and requests for review, comment, and assistance in making the Plan accessible for review and comment was sent directly to Governor Phil Bryant and the directors of the following agencies:

MS Department of Education
MS Department of Health
MS Department of Child Protection Services
MS Department of Human Services
MS Department of Human Services, Division of Aging and Adult Services
Disability Rights Mississippi, Inc.
MS Department of Rehabilitation Services
MS Institutions of Higher Learning
Office of the Governor, Division of Medicaid
Mississippi Development Authority
Department of Psychiatry and Human Behavior, University of MS Medical Center
MS Primary Health Care Association
Melody Worsham, Certified Peer Support Specialist

Although some non-service representatives on the Planning Council are also members of NAMI chapters, Mental Health Associations and/or Families As Allies for Children's Mental Health, Inc., additional copies of the Draft Plan and requests for comment were also sent to directors, presidents, or other leadership of state and local affiliates of the following family/consumer/advocacy groups:

Families As Allies for Children's Mental Health, Inc.
Mental Health Association of Mississippi
NAMI Mississippi

The response to 2.: The Planning Council continues to be expanded to include representatives of all populations. Several senior and aging adults, a representative from the VA Medical Center, and a representative from the Mississippi Band of Choctaw Indians serve on the Council. Efforts to include transition-age youth are ongoing. A major barrier is the inability of young adults to attend due to conflicts with work and school schedules. Efforts are also ongoing to encourage a member of the LGBT community and a Hispanic individual to participate on the Council.

The MS Department of Mental Health Community Mental Health Services FY 2018-2019 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Minutes and agenda from the Mississippi State Mental Health Planning and Advisory Council meetings for FY 2017 are in the Attachments. A |

Support letter from the Chair of the Mississippi State Mental Health Planning and Advisory Council is also attached

Mississippi State Mental Health Planning and Advisory Council

David Connell

Chairperson

44 Bates Lane
Hattiesburg, MS 39402

Phone: (601) 520-1096
Email: Barbeque2004@yahoo.com

Diana Mikula
Executive Director
Mississippi Department of Mental Health
239 North Lamar Street, Suite 1101
Jackson, MS 39201

Dear Ms. Mikula:

On behalf of the members of the Mississippi State Mental Health Planning and Advisory Council, I am writing this letter to describe our involvement in the development and review of the *FY 2018-2019 Mental Health Block Grant Application/Mississippi State Plan for Community Mental Health Services for Children with Serious Emotional Disturbance and Adults with Serious Mental Illness.* An overview of the activities of the Council over the past year is also included in this letter.

Council members received information on the instructions provided SAMHSA for the MHBG Application during the development process of the Plan. The process to make the FY 2018-2019 Draft State Plan available for review by the Council, as well as the public, proceeded along timelines specified by SAMHSA. Sufficient time was provided for review and comment by the public in order to comply with the federal submission timeline.

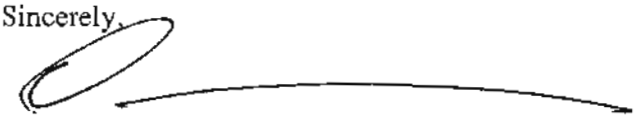
The FY 2018-19 Draft State Plan was presented for review to the Mississippi State Planning and Advisory Council via email on August 4, 2017, and approved by the Council at the August 10, 2017, meeting. The Council had the opp ortunity for further review during the public comment period from August 7, 2017, through August 28, 2017.

The Council held meetings this year on February 2, 2017, May 11, 2017, and August 10, 2017. The next Planning Council meeting is scheduled for November 2, 2017. Council members are invited and encouraged at each meeting to suggest topics on which they need or would like to have more information. Presentations were made at the meetings on the following topics at the request of the members: Primary Residential Treatment for Individuals with Substance Use Disorders, an overview and update on Personal Outcome Measures, information regarding the Association of Mississippi Peer Support Specialists (AMPSS), Commercial Insurance and

Mental Health/Substance Abuse Parity, update on 1915i, the 2016 DMH Behavioral Health Report, the FY 2018-2019 Block Grant, the CIT Program, and funding by SAMHSA. A report on the Department of Mental Health's budget is presented at every meeting by the Director of the Bureau of Administration at DMH.

It's been my honor to serve as the Chairperson for the Mississippi State Planning and Advisory Council for the last three years. The participation and perspectives of the Council members significantly contribute to moving our state forward in providing necessary and appropriate services for the individuals, children, and families in Mississippi served by the public mental health system. I appreciate the support of the Department of Mental Health and other stakeholders who partner with us as we continue to strive to meet the needs of all Mississippians with mental health challenges. Please feel free to contact me if you need additional information.

Sincerely,



David Connell
Chairperson

cc: Jake Hutchins

Mississippi State Mental Health Planning and Advisory Council Meeting

AGENDA

Thursday, July 28, 2016

1. Call to Order
   David Connell – Chairperson

2. Approval of Minutes (April 14, 2016)

3. Old Business

   A. MS Department of Mental Health Services 2016-2017 State Plan
      Kimela Smith Runnels – MS Department of Mental Health

   B. Other Old Business

4. New Business

   A. DMH Budget
      Kelly Breland – MS Department of Mental Health

   B. Consumer Satisfaction Surveys
      Susan Hrostowski – The University of Southern Mississippi

   C. Choice: Update on MS Program Providing Rental Housing Assistance for Persons
      with Serious Mental Illness
      Ben Mokry – Mississippi Home Corporation

   D. Announcements

   E. Other New Business
      Topics/Speakers
      Kimela Smith Runnels – MS Department of Mental Health

   F. Other Public Comments

5. Management Plan Calendar/Objectives and Scheduling of Next Meeting

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
July 28, 2016
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Ms. Tanya Bradley, Ms. Rachel Chandler, Hon. Mark Chaney, Ms. Amanda Clement, Ms. Meredith Clemmons, Mr. David Connell, Ms. Kay Daneault, Ms. Annette Giessner, Mr. Ronney Henderson, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Toniya Lay, Ms. Tara Manning, Dr. Janette McCrory, Mr. Ben Mokry, Ms. Ekoko Onema, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Tonya Tate, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White, Ms. Bonlitha Windham, Ms. Melody Worsham

Members Absent: Dr. Shawn Clark, Ms. Debbie Dobbins, Dr. Maxie Gordon, Ms. LaVonda Hart, Ms. Doris Ledet, Ms. Harriette Mastin, Ms. Sandra McClendon, Ms. Kim Richardson, Ms. Tameka Tobias Smith, Mr. Charlie Spearman, Ms. Kim Williams, Dr. Scott Willoughby

DMH Staff Present: Ms. Wendy Bailey, Mr. Kelly Breland, Mr. Jake Hutchins, Ms. Kimela Smith Runnells, Ms. Lynda Stewart, Ms. Carman Weaver

Guests: Ms. Bridgett Butler, Ms. Dixie Church, Ms. Kathy Crockett, Ms. Faye Culpepper, Ms. Susan Hrostowski, Mr. Mark W. Kangur, Ms. Alethea Krutz, Mr. Brett Mayfield, Ms. Demetris Neely, Ms. Rebecca Small, Mr. Scott Sumrall, Ms. Amy Turner, Ms. Debbie Waller

II. Approval of Minutes

It was moved by Mr. Mokry and seconded by Mr. Spearman that the April 14, 2016, minutes be approved as presented. The motion was carried.

III. Old Business

A. 2016 – 2017 Term for the Mississippi State Mental Health Planning and Advisory Council Kimela Smith Runnels – Mississippi Department of Mental Health

The DMH received notification from SAMHSA that the 2016-2017 State Plan was reviewed and accepted. The State Plan is not required by SAMHSA this year, however, the DMH will be required to complete a mini application. The application comprises 3 components: the composition of the Planning Council by member type, the members who serve on the Planning Council, and state agency planned expenditures. The current composition of the Mississippi State Mental Health Planning and Advisory Council is as follows: 58% of members – are those who are receiving services, or whose family members are receiving services, or who belong to advocacy organizations; 42% of members - are state employees and providers. To meet the requirement that "no less than 50% of the members are not state employees or providers of mental health services", the Planning Council needs to continue to expand membership to include representatives in the LGBT population, Latino, and area Agency on Aging. Ms. Runnels stated that she has contacted Ms. Chelsea Criddle with the Central MS Planning and Development District. Ms. Criddle agreed to serve in this capacity; however, she could not be at today's meeting. SAMHSA is also urging membership from service area populations which represent ethnic culture, rural, suburban, urban, and older adults. SAMHSA's website has expenditures listed for 2 years previous through June 30, 2016. The DMH had approximately $2 million in community health funds for FY 2015, ending now, and approximately $4.67 million in federal funds for FY 2016. Some appropriation estimates have been given for FY 2017 from the president's budget and that amount is $4.62 million, a $50,000 decrease compared to last year. It was noted that there is a maintenance of effort with these funds and in 2016, 10% was required for evidenced based practice. The DMH meets the evidenced based practice criteria with the NAVIGATE programs and the PACT teams.

B. Other Old Business

Ms. Giessner requested the status on denials for children's day treatment.

Ms. Small stated that the denials were reversed and the children scheduled to start fall day treatment services were approved.

IV. New Business

A. Department of Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health

After negotiations ended, state funds were cut $8.3 million. Mississippi State Hospital closed 2 services, which were the Medical Psychiatric Unit and the Male Chemical Dependency Unit. East Mississippi State Hospital had a Chemical Dependency Unit and a Medical Care Unit that were both discontinued. Ellisville State School had an Early Intervention Program that was discontinued. This was all to meet the budget cut given by the legislature. The Early Intervention Services were shifted back to the

Department of Health, which is actually their responsibility. It was also noted that many of the Early Intervention Services are operated through private providers.

B. Consumer Satisfaction Surveys
Susan Hrostowski – The University of Southern Mississippi

For the past 3 years the School of Social Work at USM has administered the client satisfaction surveys, compiled reports and submitted those reports to the DMH. USM did not receive the contract when it went out for bid this year. MSU was awarded the contract this year. The survey done by USM was developed through several meetings with Ms. Runnels and others from the DMH to include information SAMHSA requires and information that would be helpful. It is printed in a user friendly, pamphlet format at a 7th grade reading level. The surveys are presented by the receptionists at the CMHC's on doctor day to every other consumer until a sufficient sample of surveys is received. The consumer may ask for assistance and there is care taken with these assistants to be sure there is no bias and that the consumer feels comfortable in answering the questions honestly. The data is compiled and then the data descriptive statistics are done. Dr. Hrostowski reviewed data via PowerPoint. There were significantly more female than male responses and there were responses from 57.9% African Americans and 37.5% Caucasians. The survey rating is on a scale of 1 to 5 – 1 being great and 5 being bad. The consumer's feelings of satisfaction with the services they receive on the scale presented doesn't get past a 2.5 on the scale. Overall consumers are saying between 1.5 and 2.0, which is between really good and pretty good. Outpatient survey participation last year included 558 adults and 249 children. Mr. Hutchins noted that the DMH contracted with USM many years ago and thousands of dollars in stamps and envelopes were wasted doing a mail out survey campaign. There is never a large enough return from mailing out surveys. Also, in years past, staff at the day programs, outpatient programs, and daily living programs assisted consumers with surveys. That added another dynamic between the individuals and staff that was not satisfactory to the DMH. There are going to be limitations to this process but the DMH is striving for the best possible method. The DMH continues to encourage the regions with low response rates, reminding them that administering the surveys is of great importance in order to receive funding.

Dr. Hrostowski stated that Mr. Connell asked her to talk about a previous presentation given to mental health staff. She is a Professor of Social Work, Episcopal Priest, and a plaintiff in two high profile court cases. She and her wife, who is the Executive Director of the Aids Services Coalition in Hattiesburg, sued the state in order for her to adopt their son, who her wife gave birth to through artificial insemination. They had planned for Dr. Hrostowski to adopt him after his birth; however, the law stating that "no two people of the same gender could adopt a child in Mississippi" went into effect when he was 6 weeks old. The law suit was won and Dr. Hrostowski was able to adopt their son one month after his 16th birthday. Dr. Hrostowski is also a plaintiff in one of the suits against the Governor regarding HB1523. The law suit was won; however, the Governor and the Executive Director of the Department of Human Services are appealing. The Attorney General is not appealing. She relates what it's like to be a member of the

LGBT community in the social context of living in the "buckle of the Bible belt." LBGT people in the south experience a lot of depression, anxiety, alcohol and drug abuse, and suicidality. A transgender woman was murdered last week and she was the second in about two weeks. Transgender women of color are at highest risk for murder. In addition to all of this, there are mental health issues and issues that are unrelated to gender identity or sexual orientation. All of these things have to be carefully considered when diagnosing an individual.

C. CHOICE - Update on MS Program Providing Rental Housing Assistance for Persons with Serious Mental Illness
Ben Mokry – Mississippi Home Corporation

Mr. Mokry wanted to follow Dr. Hrostowski by saying that MHC (Mississippi Home Corporation) administers the federal grant, Housing for Persons with Aids Program. The Jackson area has the highest incidents of HIV Aids for African American males with the youngest group being 12-13 years old. There is immeasurable alienation in that population and the complicating factors are also physical and sexual abuse. By the time these youth become adults they have experienced many things in their lives. MHC is working to help and would love to work with anyone who is concerned about this topic.

CHOICE (Creating Housing Options in Communities for Everyone) is a program that was funded 2 years ago by the state of Mississippi in response to DOJ concerns regarding housing options outside of institutional care. MHC had no inherent knowledge about the mental health population or how to really work with the mental health side. With the commitment and responsiveness of Mr. Hutchins and his staff, MHC was able to build this new program. CHOICE is for individuals diagnosed with SMI (Serious Mental Illness) and the qualifications are as follows: 1) Individuals being discharged from a State psychiatric hospital after a stay of more than 90 days, or a nursing/intermediate care facility for individuals with intellectual disabilities after a stay of more than 90 days; 2) Individuals who have been discharged from a State psychiatric hospital within the last 2 years and had multiple hospital visits, known to have been arrested or incarcerated with mental illness; homeless 1 year or 4 or more episodes in last 3 years; 3) Individuals with SMI diagnosis who lack a fixed, regular, and adequate nighttime residence. MHC tries to work quickly to get individuals placed. Some came and decided to go back with family, others refused housing, deciding they didn't want the help. Several referrals didn't have any type of mental health diagnosis and were referred to programs that had funds to serve their needs. There are actually a number of families who are placed. People with their children, that's a good outcome. Mr. Mokry reviewed data via PowerPoint. 43% of the individuals that came through the program were either housed or are in the process of finding housing. 65% were housed within 30 days of entering the program. Finding vacant affordable rental housing in central Mississippi can be a challenge. It's a learning process but it will certainly be successful.

D. Announcements

- Consumer Rights Meeting
  12:30-1:30 Today, Conference Room, MSH
  Following Planning Council Meeting

- Trauma Informed Care Conference
  September 20 – 22, 2016, at the Jackson Convention Complex, Jackson, MS
  www.2016traumainformedcareconference.weebly.com

- NAMI Walk Mississippi
  November 5, 2016, at the Mississippi Museum of Art, Jackson, MS
  For more information go to www.namims.org or visit their Facebook page

E. Other New Business
Topics/Speakers
Kimela Smith Runnels – Mississippi Department of Mental Health

No New Business

Speakers/Topics for Next Meeting:

- Update from the Bureau of A&D Services on the impact of the chemical dependency unit cuts

- Information regarding the absence of the shared service charges part of the budget

- Council discussion of the Consumer Satisfaction Survey

F. Other Public Comments

None

V. Management Plan Calendar/Objectives and Scheduling of Next Meeting

The next Mississippi State Mental Health Planning and Advisory Council meeting is scheduled for ***Thursday, November 10, 2016*** at *10:00 a.m.* in the conference room of Building 56 at MSH.

VI. Adjournment

With no further business the meeting was adjourned.

Mississippi State Mental Health Planning and Advisory Council Meeting

AGENDA

Thursday, November 10, 2016

1. Call to Order – **David Connell** – Chairperson

2. Approval of Minutes (July 28, 2016)

3. Old Business

   A. Department of Mental Health 2016 Behavioral Health Report
      Kimela Smith Runnels – MS Department of Mental Health

   B. Other Old Business

4. New Business

   A. DMH Budget
      Kelly Breland - MS Department of Mental Health

   B. Choice Program at the Local Level
      Mary Simmons- Open Doors Homeless Coalition

   C. DMH's Disaster Preparedness and Response Plans
      Randy Foster – MS Department of Mental Health

   D. Announcements

   E. Other New Business
      Topics/Speakers
      Kimela Smith Runnels – MS Department of Mental Health

   F. Other Public Comments

5. Management Plan Calendar/Objectives and Scheduling of Next Meeting

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
November 10, 2016
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Ms. Tanya Bradley, Ms. Rachel Chandler, Hon. Mark Chaney, Ms. Amanda Clement, Mr. David Connell, Dr. Chelsea B. Crittle, Ms. Kay Daneault, Ms. Annette Giessner, Mr. Ronney Henderson, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Toniya Lay, Ms. Tara Manning, Ms. Sandra McClendon, Ms. Ekoko Onema, Ms. Elaine Owens, Mr. John Quinos, Ms. Tameka Tobias Smith, Ms. Tonya Tate, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White, Dr. Scott Willoughby

Members Absent: Dr. Shawn Clark, Ms. Meredith Clemmons, Ms. Debbie Dobbins, Dr. Maxie Gordon, Ms. LaVonda Hart, Ms. Harriette Mastin, Dr. Janette McCrory, Mr. Ben Mokry, Ms. Coreaner Price, Ms. Kim Richardson, Mr. Charlie Spearman, Ms. Kim Williams, Ms. Bonlitha Windham, Ms. Melody Worsham

DMH Staff Present: Ms. Aurora Baugh, Mr. Andrew Day, Mr. Randy Foster, Mr. Brent Hurley, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Kimela Smith Runnells, Ms. Veronica Vaughn, Ms. Carman Weaver

Guests: Ms. Tiffany Anderson, Ms. Toronda Robinson, Ms. Mary Simons, Ms. Amy Turner, Ms. Debbie Waller, Ms. Dwyla Wilson

II. Approval of Minutes

It was moved by Ms. Kinnan and seconded by Dr. Kinnan that the July 28, 2016, minutes be approved as presented. The motion was carried.

The council observed a moment of silence in respect for Ms. Melody Worsham's son who passed away.

III. Old Business

A. Department of Mental Health 2016 Behavioral Health Report
Kimela Smith Runnels – Mississippi Department of Mental Health

The 2016 Behavioral Health Report is due December 1st. This report indicates whether or not we achieved our objectives. After it is approved, Ms. Runnels will put it on the shared server.

B. Other Old Business

The latest update regarding the DOJ is that they have filed a lawsuit against the state.

IV. New Business

A. Department of Mental Health Budget Update
Jake Hutchins – Mississippi Department of Mental Health

Jake Hutchins reported for Kelly Breland due to budget hearings at the Legislature. Since the last council meeting, the DMH received an additional $44,000 budget cut designated for Central Office.

B. Choice Program at the Local Level
Mary Simons – Open Doors Homeless Coalition

The Choice Program is a partnership between the Community Mental Health Centers (CMHC), DMH (Department of Mental Health), MHC (Mississippi Home Corporation), CoC (Continuum of Care) agencies in the state, and other community partners to provide housing for people who are either exiting institutional care or who are homeless living with mental illness in need of stabilization services and housing. The goal is to ensure successful transitions and support so they are able to live their lives to their fullest potential. This is a community based, state based effort bringing in all of the partners with knowledge and resources helpful to people depending on their individual needs. MHC provides rental subsidies for housing for up to a year, the CMHC's provide mental health care, the CoC organization assists with housing issues, such as housing inspections. Choice is also adding some stabilization activities that include regular home visits from Case Managers to supplement what the CMHC's are able to do. On the Gulf Coast, Choice has been able to achieve some goals towards ending homelessness helping our veterans. In the 6 lower counties of Mississippi, if a veteran falls into homelessness, whether he or she has a mental illness or not, they are able to get into housing within 11 days. This is a proof point that Choice has been able to create collaborations and systems to ensure that this can be done and it can be done with other populations as well. It is a matter of scale, increasing what works, learning, and course correcting when something doesn't work. Choice is creating partnerships that are win-win most importantly between the community and the people who are in our system.

C. DMH's Disaster Preparedness and Response Plans
Randy Foster – Mississippi Department of Mental Health

When a disaster is declared, calls come from FEMA through MEMA requesting a number for mental health emergencies/contacts. Mr. Foster relays the Mobile Crisis

Team information for the designated region as well as the DMH Helpline number, which is available 24/7. The Mobile Crisis Teams are enlisted during disasters to serve as crisis counselors and the DMH has 14 teams statewide. The DMH follows the Comprehensive Emergency Management Plan (CEMP) which involves all activity filtering through the hub of the Emergency Operations Center (EOC). Formal evacuation plans are in place and evacuation drills are performed yearly. Client care and safety is the primary focus during an emergency.

D. Announcements

Consumer Rights Meeting
12:00 Today, Conference Room, MSH
Following Planning Council Meeting

E. Other New Business
Topics/Speakers
Kimela Smith Runnels – Mississippi Department of Mental Health

No New Business

Speakers/Topics for Next Meeting:

Region 12 Representative regarding SAMHSA's Sequential Intercept Mapping (SIM) Workshops

F. Other Public Comments

None

V. Management Plan Calendar/Objectives and Scheduling of Next Meeting

The dates for the 2017 Mississippi State Mental Health Planning and Advisory Council meetings will be sent out by Ms. Runnels. The time and place will remain the same at *10:00 a.m.* in the conference room of Building 56 at MSH.

VI. Adjournment

With no further business the meeting was adjourned.

Mississippi State Mental Health
Planning and Advisory Council Meeting

AGENDA

Thursday, February 2, 2017

1. Call to Order – **David Connell** – Chairperson

2. Approval of Minutes (November 10, 2016)

3. Old Business

   A. Department of Mental Health 2016 Behavioral Health Report
      Wendy Bailey – MS Department of Mental Health

   B. Other Old Business

4. New Business

   A. DMH Budget
      Kelly Breland – MS Department of Mental Health

   B. Primary Residential Treatment for A&D Update
      Melody Winston/Michael Jordan – MS Department of Mental Health

   C. Personal Outcome Measures Overview
      Martha Mitchell – The Arc of Mississippi
      Aurora Baugh – MS Department of Mental Health

   D. Association of Mississippi Peer Support Specialists (AMPSS)
      Melody Worsham – Mental Health Association of South Mississippi

   E. Announcements

   F. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
February 2, 2017
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Ms. Tanya Bradley, Ms. Rachel Chandler, Dr. Shawn Clark, Ms. Amanda Clement, Mr. David Connell, Ms. Annette Giessner, Dr. Maxie Gordon, Mr. Ronney Henderson, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Tara Manning, Ms. Sandra McClendon, Mr. Ben Mokry, Ms. Ekoko Onema, Ms. Elaine Owens, Mr. John Quinones, Ms. Kim Richardson, Mr. Charlie Spearman, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White, Ms. Melody Worsham

Members Absent: Hon. Mark Chaney, Ms. Meredith Clemmons, Dr. Chelsea B. Crittle, Ms. Kay Daneault, Ms. Debbie Dobbins, Ms. LaVonda Hart, Ms. Toniya Lay, Ms. Harriette Mastin, Dr. Janette McCrory, Ms. Coreaner Price, Ms. Tameka Tobias Smith, Ms. Tonya Tate, Ms. Kim Williams, Dr. Scott Willoughby, Ms. Bonlitha Windham

DMH Staff Present: Mr. Steven Allen, Ms. Wendy Bailey, Ms. Aurora Baugh, Mr. Kelly Breland, Mr. Andrew Day, Mr. Jake Hutchins, Mr. Michael Jordan, Ms. Molly Portera, Ms. Lynda Stewart, Ms. Veronica Vaughn, Ms. Carman Weaver, Ms. Melody Winston

Guests: Ms. Michele Bates, Ms. Gay Gipson, Mr. Perry Gipson, Mr. Thomas Hart, Mr. Jerry Mayo, Ms. Martha Mitchell, Ms. Debbie Waller

II. Approval of Minutes

It was moved by Mr. Larry Waller and seconded by Ms. Sandy Kinnan that the November 10, 2016, minutes be approved as presented. The motion was carried.

III. Old Business

A. Department of Mental Health 2016 Behavioral Health Report
Wendy Bailey – Mississippi Department of Mental Health

Ms. Veronica Vaughn and Ms. Molly Portera will be the new contacts for council members. It is time to elect a new term of officers. A motion was made by Mr. Charlie Spearman to re-elect Mr. David Connell as Chair, Ms. Wendy Bailey brought the motion to the floor and the motion was carried. A motion was made by Ms. Amanda Clement to

serve as Vice-Chair, Ms. Bailey brought the motion to the floor and the motion was carried. A motion was made by Ms. Clement to re-elect Ms. Annette Giessner as Parliamentarian, Ms. Bailey brought the motion to the floor and the motion was carried. A motion was made by Ms. Clement to re-elect Ms. Sandy Kinnan as Secretary, Ms. Bailey brought the motion to the floor and the motion was carried. The new slate of officers is as follows: Chair, Mr. David Connell; Vice-Chair, Ms. Amanda Clement; Parliamentarian, Ms. Annette Giessner; Secretary, Ms. Sandy Kinnan.

B. Other Old Business

None

IV. New Business

A. Department of Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health

The proposal from the Legislative Budget Office for fiscal year 2018 is approximately $7.9 million in general funds less than what was originally appropriated in fiscal year 2017 and includes a cut to the Special Funds spending authority. The DMH has received steady cuts one of which was issued in September 2016 to the central office in the amount of $44,000 and another issued 3 weeks ago with the department receiving an overall 1.45% decrease in state funds. It was noted that the governor can cut and selectively exempt agencies from cuts; however, once an agency's budget has been cut within 5% it can't be cut any further until all of the other agencies have been cut to 5% as well. The DMH maintains two areas of priority which are Direct Care Worker realignment and state shares for Home and Community Based Services for IDD Waiver. Direct Care Worker realignment has been an issue despite the lack of funding in the state. The difference is between an annual salary of $17,408.98 and $20,020.28. An estimated $5.3 million must come from the state's general funds to continue into fiscal year 2018 for Home and Community Based Services for IDD Waiver. The appropriations process should be finished around the last week of March.

There was much discussion regarding hiring and training direct care staff and that this is the majority of what is being called a "pay raise" within the DMH. The process to hire direct care staff is to first hire a Direct Care Worker Trainee, after 3 weeks of training and a total of 3 months on the job, that person is moved to a Direct Care Worker position with an increase in pay of $3,000. The turnover rate among these employees is 47% (and in some cases 81%) which leaves a vicious cycle of hiring, training, and giving "pay raises" when in actuality this is part of their salary that is simply added after 3 months of hire.

B. Primary Residential Treatment for A&D Update
Melody Winston/Michael Jordan – Mississippi Department of Mental Health

Michael Jordan, the State Opioid Treatment Authority (SOTA) for Mississippi, maintains oversight of the Opioid Treatment Programs (OTP's) which is a requirement of the

federal government. The nationwide epidemic has increased 300% in opioid use or death since 2014. The areas in our state that are most active according to the Mississippi Bureau of Narcotics in the north region are DeSoto, Tishomingo, and Alcorn counties; in the central region are Hinds, Madison, and Rankin counties; and the counties along our coastal area. The DMH is in the process of applying for the Mississippi State Targeted Opioid Prescription Project (MS-STOP) modeled after the SAMHSA Opioid Overdose Prevention Toolkit. Once the application is approved, with our strategies in place and the governor's task force at work, our communities should reflect much better data than the increases that have been reported over the last couple of years. There is also legislation, House Bill 996, "Emergency Response and Overdose Prevention Act," authored by Rep. Patricia H. Willis, Chair of the Drug Policy Committee, that permits dispensing the opioid antagonist Narcan (with proper training) to reverse an overdose. This would allow trained first responders, firefighters, law enforcement officers, or emergency medical technicians to administer Narcan in emergency situations. There is currently only enough funding to supply Narcan to the most crucial areas of the state.

C. Personal Outcome Measures Overview
Martha Mitchell – The ARC of Mississippi
Aurora Baugh – Mississippi Department of Mental Health

The DMH in partnership with The Arc of Mississippi has implemented Personal Outcome Measures (POM) to assess the impact of quality of life for people receiving disability services for mental illness. The Arc of Mississippi annually trains and certifies PEER interviewers to collect POM data. Interviewers collect data by talking with the individuals receiving services as well as staff. These outcome measures are divided into 3 categories and 21 outcomes that are most important to people receiving services. The 3 categories include: 1) My Self – Who I am as a result of my unique heredity, life experiences, and decisions; 2) My World – Where I work, live, socialize, belong, or connect; and, 3) My Dreams – How I want my life (self and world) to be. The last full review was in fiscal year 2014. Since that review, POM has taken 7 samples from CMHC's. A sample consists of interviewing at least 4 individuals, a staff member, and is followed by a meeting with the DMH staff to discuss results of the findings. The DMH certification ensures individuals are getting quality services based on guidelines in the Operational Standards and the POM enhances that by the added aspect of communication with the individuals regarding their view of services. Based on the 2014 data for adults from the CMHC's, the individuals had the following concerns: the system is not self-directed; they felt they did not have a choice in the direction their services were going; they did not feel like they were part of the community even though they lived there; they felt that they didn't have social roles; they felt they didn't have choices in jobs and their housing situations. After receiving these findings, the DMH sorted through this information, more data was collected, and a plan was developed to implement a more supportive person-centered, recovery oriented system. The focus has been broadened from clinical concerns and is now shared with issues such as quality of life, housing, social roles, meaningful days, and resources. The DMH made changes to the Record Guide, Operational Standards, and in the way programs are reviewed. DMH staff was trained to look through the lens of recovery and incorporate

POM. The CMHC's were trained on changes for future site visits and POM staff provided technical assistance. Scores from previous years will be used as a base for the upcoming year and an improved outcome is expected.

D. Association of Mississippi Peer Support Specialists (AMPSS) Melody Worsham – Mental Health Association of South Mississippi

The Association of Mississippi Peer Support Specialists (AMPSS) is a statewide network with approximately 150 members. The Executive Board: Chair, Stephanie Stout; Vice-Chair, Curtis Oliver; Secretary, Melody Worsham; and Treasurer, Jess Whatley, are representatives from across the state. There is representation and leadership from every area of Mississippi which is important because peer support needs vary from region to region. The membership is diverse and includes a legislator, agency affiliates, peers, and family members. New members are welcome and can be anyone interested in promoting peer support as a recovery oriented way of caring for people or anyone who believes in peer support. AMPSS began as part of the DMH and with their support and help, by 2015 was an independent corporation. Last year AMPSS received a grant from the DMH and has been able to accomplish some great things, one of which is the Meaningful Participation Toolkit Project. The act of "meaningful participation" is unique to everyone in society. When a person chooses to do something that is meaningful to them, that person wants assurance that they belong, their input matters, and they are part of something. One aspect of this toolkit is assisting with these types of personal outcome goals. These goals could range from helping with initiating participation to leading to a better voice to having solidarity among peers in society. AMPSS is building a new website to be launched July 1st. This will serve as a central hub for communication, information, and educational opportunities. The website will have a member's only tab that will give peers access to things such as job announcements and problem solving forums. The website will have other information integrated for those who are in search of resources, recovery oriented information, mental health partners information, and webinars. AMPSS would like to continue the great work of the Mississippi Leadership Academy. AMPSS has an annual Peer Summit to offer additional learning opportunities and reward those who have worked extra hard during the previous year.

E. Announcements

- NAMI Lunch & Learn for MS Southwest Region
  February 15th noon-1:00pm • King's Daughters Medical Center
- NAMI Day at the Capitol
  February 23rd 7:30am-10:30am • Room 210
- NAMI State Conference
  May 18th-20th Belhaven University
- NAMI Walk
  Veteran's Day, November 11th

F. Other New Business
Topics/Speakers

A federal monitoring visit will be made by SAMHSA February 28th through March 3rd. In 2012 the reviewers were able to attend a planning council meeting, however, if this is not an option, an impromptu meeting may be called for members who live locally.

Speakers/Topics for Future Meetings:

- 1915i Information/Funding Update
- Update on SMI and DOJ Investigation
- Rachel Chandler, MS Insurance Department, Parity Policy Academy

G. Other Public Comments

Mr. Thomas Hart, Disability Policy Engagement Director with Anthem, Inc., presented some information about Amerigroup. This is a Medicaid provider being utilized in 21 other states that was developed in Iowa. Amerigroup employs Peer Support Specialists as links in their communities because they are familiar with their community networks.

V. Management Plan Calendar/Objectives and Scheduling of Next Meeting

Peer Support Specialist Training at DMH is scheduled for March 28-31, 2017.

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, May 11, 2017 at 10:00 a.m.

VI. Adjournment

The meeting was adjourned.

Mississippi State Mental Health
Planning and Advisory Council Meeting

AGENDA
Thursday, May 11, 2017

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (February 2, 2017)

3. Old Business

   1915i Update – **Jake Hutchins** – MS Department of Mental Health
   Director, Bureau of Community Mental Health Services

4. New Business

   A. DMH Budget Update
   Kelly Breland – MS Department of Mental Health
   Director, Bureau of Administration

   B. Commercial Insurance and Mental Health/Substance Abuse Parity
   Andrew Day – MS Department of Mental Health
   Director, Division of Adult Community Services
   Rachel Chandler, Esq. – Mississippi Insurance Department
   Supervisor, Live and Health Actuarial Division

   C. Announcements

   D. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
May 11, 2017
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Ms. Rachel Chandler, Hon. Mark Chaney, Dr. Shawn Clark, Mr. David Connell, Dr. Chelsea B. Crittle, Ms. Kay Daneault, Ms. Annette Giessner, Dr. Maxie Gordon, Mr. Ronney Henderson, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Toniya Lay, Dr. Janette McCrory, Ms. Coreaner Price, Mr. John Quinones, Mr. Charlie Spearman, Ms. Tonya Tate, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White

Members Absent: Ms. Tanya Bradley, Ms. Amanda Clement, Ms. Meredith Clemmons, Ms. Debbie Dobbins, Ms. LaVonda Hart, Ms. Tara Manning, Ms. Harriette Mastin, Ms. Sandra McClendon, Mr. Ben Mokry, Ms. Ekoko Onema, Ms. Elaine Owens, Ms. Kim Richardson, Ms. Tameka Tobias Smith, Dr. Scott Willoughby, Ms. Bonlitha Windham, Ms. Melody Worsham

DMH Staff Present: Ms. Wendy Bailey, Mr. Kelly Breland, Mr. Andrew Day, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Molly Portera, Ms. Veronica Vaughn, Ms. Carman Weaver

Guests: Ms. Tiffany Anderson, Ms. Debbie Waller

II. Approval of Minutes

It was moved by Mr. Charlie Spearman and seconded by Mr. Larry Waller that the February 2, 2017, minutes be approved as presented. The motion was carried.

III. Old Business

A. 1915i Update
Jake Hutchins – Mississippi Department of Mental Health

Finalizing the 1915i for the adult IDD population continues to be a long process. The DMH is exploring consumer run type services for Supported Employment and Housing Supports. The 1915i is very expensive and the requirement to fund IDD Waiver program costs for the new year adds to the budget but the DMH will continue to pursue

the 1915i. Ms. Bonlitha Windham is leaving Medicaid and going to Child Protection Services, however, the DMH anticipates a great working relationship with Medicaid as always. To get parity and substance abuse reimbursement for the CMHC's and other providers through Medicaid is the current primary focus. The DMH submitted a state plan amendment in the past for Medicaid substance abuse treatment reimbursement but it remains very limited. Mr. Hutchins and Ms. Melody Winston, Bureau of Alcohol & Drug Director, has a meeting set with Medicaid week after next.

IV. New Business

A. Department of Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health

The 2017 Legislative Session ended with a reduction in general funds for FY18 totaling $19,732,261 with an extra requirement to fund 2,515 ID/DD Home and Community Based Waiver slots. These are estimated to cost $5,350,400. Two PACT Teams will not receive funding for fiscal year 2018. The DMH felt that these were vital to the communities they serve and secured an additional $900,000 to keep these teams open. The DMH Board of Directors approved a reduction in workforce by the end of the 2018 fiscal year to include retirees, agency departures, current vacancies, and a reduction in force. More specifically, the Crisis Stabilization Unit (CSU) and the Footprints Program at Central Mississippi Residential Center (CMRC) will transition to Weems Community Mental Health Center on July 1, 2017. These programs are not being eliminated, but are being transitioned to another provider. Due to low occupancy, the acute inpatient child and adolescent units at East Mississippi State Hospital (EMSH) and Mississippi State Hospital (MSH) will be consolidated. ID/DD Home and Community Based Waiver enrollment has been ceased at this time due to an expected increase in reimbursement rates and the loss of the Balancing Incentive Program funding through Medicaid, which previously supplemented these waivers. Admissions to the five IDD Regional Programs (Hudspeth Regional Center, Boswell Regional Center, Ellisville State School, South Mississippi Regional Center, and North Mississippi Regional Center) and the nursing homes at East Mississippi State Hospital and Mississippi State Hospital. These services continue to be offered by other providers throughout the state.

B. Commercial Insurance and Mental Health/Substance Abuse Parity
Andrew Day – Mississippi Department of Mental Health
Rachel Chandler, Esq. – Mississippi Insurance Department

Mr. Andrew Day represented the DMH and Ms. Rachel Chandler represented the Mississippi Insurance Department at the Commercial Insurance Parity Policy Academy sponsored by SAMHSA. Parity means that insurance companies who provide coverage for mental health or substance use disorders should provide equal coverage of that for a medical issue. The Mississippi Insurance Department is currently working with a coach assigned by SAMHSA to assist in developing an action plan realistic and sustainable for Mississippi. In addition, they are helping to develop a plan to accomplish the objectives necessary to establish the enforcement in the commercial market. Priorities at the Mississippi Insurance Department are: Education and Outreach, Non-Quantitative

Treatment Limitations (NQTL), Market Conduct, Network Adequacy, Develop Regulations for Parity Interpretation. The Insurance Department plans to develop regulations for interpretation on how providers are to interpret the law, education and outreach, and market conduct/network adequacy. There is a need to develop and insure that everyone can interpret the law the way it will be upheld and enforced. Education and Outreach is a main concern because many consumers are not aware of their coverage, especially regarding certain mental health issues. It's not that they aren't covered, they don't know and because they don't know, they aren't complaining. Using NTQL Analysis, a Market Conduct Exam can be done as well as an on-site visit with a panel discussion when it is deemed necessary. In addition, a Stakeholders Advisory Board was created and has met twice. The minutes of these meetings will be made public.

C. Announcements

- NAMI Mississippi 2017 Annual Conference
  May 18th-19th • Belhaven University
- NAMI Mississippi Signature Programs Training Academy
  July 28th-30th • Eagle Ridge Conference Center
  for information call 601-899-9058 or email education@namims.org
- NAMI Pine Belt (MS) Affiliate Minority Mental Health Forum
  July 8th • Forrest County Chancery Court
- NAMI Walk
  Veteran's Day, November 11th

D. Other Public Comments

Ms. Molly Portera asked that everyone present sign the attendance sheet. Attendance is required for various reports. Also, a reminder to the members regarding the absence policy, a member with 3 unexcused absences in a fiscal year will be dropped from the Council, after 2 unexcused absences a letter will be sent to find out if you are still interested in being a part of the committee.

On May 16th Mr. Andrew Day will be moving to the Certification Department. Mr. Hutchins expressed his gratitude and commended him for all he has done for Adult Services through the years.

Ms. Tiffany Anderson, Region 9, stated that after establishing a relationship with the Clinton Police Department, 4 of their officers began the Crisis Intervention Team (CIT) training this week. St. Dominic Hospital has agreed to be the single point of entry and the Memorandum of Understanding is being finalized. Ms. Anderson will be a presenter at the NAMI conference and the presentation will be focusing on mental wellness specific to law enforcement.

IV. Scheduling of Next Meeting/Topics

Topics:

- CIT Update
- SAMHSA Funds
- Federal Report Final Draft (if available)

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, August 10, 2017 at 10:00 a.m.

V. Adjournment

The meeting was adjourned.

Mississippi State Mental Health
Planning and Advisory Council Meeting

AGENDA
Thursday, August 10, 2017

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (May 11, 2017)

3. Old Business

   A. MS Department of Mental Health 2018-2019 State Plan Draft Approval
      Kathy VanCleave – MS Department of Mental Health
      Director, Alzheimer's, Autism and Recovery Supports

4. New Business

   A. DMH Budget Update
      Kelly Breland – MS Department of Mental Health
      Director, Bureau of Administration

   B. CIT Program
      Brent Hurley – MS Department of Mental Health
      Director, Division of Crisis Services

   C. SAMHSA Funds
      Jake Hutchins – MS Department of Mental Health
      Director, Bureau of Community Mental Health Services

   D. Announcements

   E. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
August 10, 2017
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Hon. Mark Chaney, Dr. Shawn Clark, Ms. Amanda Clement, Ms. Meredith Clemmons, Mr. David Connell, Ms. Kay Daneault, Ms. Annette Giessner, Dr. Maxie Gordon, Mr. Ronney Henderson, Ms. Toniya Lay, Mr. Mark Leiker, Ms. Tara Manning, Dr. Janette McCrory, Ms. Ekoko Onema, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Kim Richardson, Ms. Tonya Tate, Mr. Larry Waller, Dr. Scott Willoughby, Ms. Melody Worsham

Members Absent: Ms. Tanya Bradley, Ms. Rachel Chandler, Dr. Chelsea B. Crittle, Ms. Debbie Dobbins, Ms. LaVonda Hart, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Harriette Mastin, Ms. Sandra McClendon, Mr. Ben Mokry, Mr. John Quinones, Ms. Tameka Tobias Smith, Mr. Charlie Spearman, Mr. Harold White, Ms. Nancy White

DMH Staff Present: Ms. Wendy Bailey, Mr. Kelly Breland, Mr. Brent Hurley, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Kathy VanCleave, Ms. Veronica Vaughn, Ms. Carman Weaver

Guests: Ms. Debbie Waller

II. Approval of Minutes

It was moved by Mr. Waller and seconded by Hon. Chaney that the May 11, 2017, minutes be approved as presented. The motion was carried.

III. Old Business

A. MS Department of Mental Health 2018-2019 State Plan Draft Approval
Kathy VanCleave – Mississippi Department of Mental Health
Director, Alzheimer's, Autism and Recovery Supports

Mr. Connell read the letter prepared for submission to Ms. Mikula regarding the State Plan. It was moved by Hon. Chaney and seconded by Ms. Tate that the DMH

Community Mental Services Draft FY 2018-2019 State Plan be approved. The motion was carried. Ms. Kathy VanCleave will be the new contact person for council members.

IV. New Business

A. Department of Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health

The Mississippi Department of Finance and Administration introduced, through legislation, a new form in an effort to reduce the cost of travel, specifically mileage. The Trip Optimizer System is a spread sheet to calculate rates for renting a vehicle vs. traveling in a privately owned vehicle and receiving a reduced rate in mileage. This applies only to trips that are over 100 miles a day. Any travel that is less than 100 miles per day should be processed as it has been in the past. When the Trip Optimizer lists the calculations, if it costs more to rent a vehicle, then you can get .53 per mile to travel in a privately owned vehicle. If the lease vehicle is less, then you have 2 options: 1) lease a vehicle and get reimbursed for the expenses that accompany it, or 2) take a privately owned vehicle with a reduced rate of .17 per mile. This also applies to contract workers.

The difference between the appropriations bill authorized by the Mississippi State Legislature for fiscal year 2017 and fiscal year 2018 is approximately $14.5 million, not including Section 22 which deals with the ID/DD Waiver. A year ago, the DMH requested an increase in Waiver of approximately $5.3 million to fund Medicaid credits that kept the department from having to pay Medicaid match, but those credits stopped about 2 years ago. However, with the state's economic situation concerning state agencies, in the end the DMH received less in appropriations in order to be given the Waiver money. Section 22 requires a minimum number of Waiver slots, which is 2,515, be funded and it also puts a cap on the amount that can be spent on the Waiver, which is $28.5 million. The DMH is trying to meet both of these requirements. The $5.3 million had to come from DMH programs where there are general funds but regularly ends up coming from MSH and EMSH. This better explains how $5.3 million in addition to $14.4 million, comes closer to the $20 million general fund reduction, everywhere except the Waiver. There were 4 main repercussions from the $20 million reduction. The Crisis Stabilization Units were transitioned or consolidated. The Adolescent Unit at EMSH consolidated with the Adolescent Unit at MSH. Admissions to Nursing Homes and IDD Regional Centers ceased. Admissions to the ID/DD Home and Community Based Waiver ceased. Administrative mergers at state hospitals are underway but remain incomplete. An example of administrative mergers would be last year's merge between MS Adolescent Center and Boswell Regional Center. They operated somewhat independently but both were controlled by Boswell Regional Center. This past July 1st, Specialized Treatment Facility, which merged with MSH, NMSH, SMSH, and Central MS Residential Center, merged with EMSH. Each facility still maintains their autonomy with many things, carving out a section for their budget from EMSH, but they aren't recognized at the legislative level. Over time and through attrition there will be some reduction. This will allow EMSH for fiscal year 2018-19 to submit 1 budget request and list 3 entities. A year ago the DMH would have submitted 15 budgets to the legislature,

3 at Central Office and 12 agencies. This will bring it to 9 budgets and the immediate plan is to shorten the list by having some IDD facilities merge as well. The end goal is to have 2 budgets at Central Office and 5 budgets for the facilities, still maintaining some independent identity.

B. CIT Program
Brent Hurley – Mississippi Department of Mental Health
Director, Division of Crisis Services

The CIT (Crisis Intervention Team) "Memphis Model" is a nationally known innovative police based first responder program designed to divert individuals in mental illness crisis from arrest and jail. The program is an evidence-based practice and fully supported by NAMI. The core elements of the program are partnerships between law enforcement, advocacy and mental health. The DMH helps to set up and develop the CIT Programs to accommodate the unique needs of each community. Lauderdale County Sheriff Billie Sollie organized the first CIT Program in the state with the Meridian Police Department, Weems Community Mental Health Center, NAMI and the Newton County Crisis Stabilization Unit in 2009. Through a grant, the DMH was able to expand CIT Programs across the state. A portion of that money was awarded to the Lauderdale County Sheriff's Department to expand training to officers from outside agencies and jurisdictions to experience CIT training with officers from Lauderdale County and the Meridian Police Department. Jones County started a CIT Program and their first CIT Training Academy was held in September 2016. Laurel and Pine Belt Mental Health did training with the Forrest County Police Department, Hattiesburg Police Department and Petal Police Department. In May 2017, the DeSoto County Sheriff's Department along with Southaven Police Department, Hernando Police Department, Walls Police Department, Olive Branch Police Department and Horn Lake Police Department all started their first CIT Programs. Next month the DMH is doing training for their dispatchers. Hinds County and the Jackson Police Department have been working to establish a CIT Program for many years but have been unsuccessful due to administrative turnover in the city's offices. However, Sheriff Mason is interested in starting a CIT program, St. Dominic and Merit are discussing a single point of entry and Hinds Behavioral Health Services is promoting the program. Jackson Public Schools are involved as well as the Clinton Police Department. Adams County, their Chancery Clerk and local Crisis Response Coordinator for Region 11 are working to start a CIT Program and are negotiating a single point of entry. The DMH partnered with the Department of Public Safety and developed a joint certificate certifying the officers who have completed 40 hours of training as a certified CIT Officer in accordance with Mississippi Code 41-21-133 and it is signed by Ms. Mikula and Commissioner Fisher. The officers also receive 40 hours of continuing education and dispatchers will receive 8 hours of continuing education which will be recognized by the Department of Public Safety.

C. SAMHSA Funds
Jake Hutchins – Mississippi Department of Mental Health
Director, Bureau of Community Mental Health Services

• Total Block Grant Award	$4,884,299.00
• 5% Administrative Set Aside	$244,215.00
• 10% Set Aside (Required)	$428,855.00
• Amount to be Awarded	$4,211,229.00
• Children's Amount 45%	$1,895,053.00
• Adult Amount	$2,316,176.00

Block Grant expenditures include POS (Purchase of Service) Grants offering mental health services and providing indigent individuals with a source of payment based on Medicaid rate reimbursement. Intensive Community Support Grants, previously Case Management, provides individuals with more intensive Case Management to avoid out of home placement and transitioning from inpatient treatment. Non-Community Mental Health Center Grants are awarded to NAMI, Mental Health Association – Drop in Center, and The Arc of Mississippi for Personal Outcome Measures. Block Grant expenditures for Children and Youth include Juvenile Outreach Program Grants that provide mental health services to youth while they are in detention centers. POS Grants providing a source of payment (at Medicaid rate reimbursement) and mental health services in areas where there are higher commitment rates for children. Community Service Providers Grants include: Southern Christian Services Respite for Families, Gulf Coast Women's Center Intensive Community Support that with children of families from domestic violence situations where trauma is involved, Catholic Charities working with the Hinds County MAP Team, Vicksburg Family Development offering Early Childhood Intervention for at risk children or who have SED, and 2 Community Mental Health Centers offering Wraparound Certification Training. The NAVIGATE Program Grant that serves adolescent and young adults who have experienced their first episode of psychosis. The NAVIGATE Programs located in Region 6 and Region 13 constitute the required 10% set-aside by CMS to provide evidence-based programs. The DMH plans to start at least 1 new NAVIGATE Program.

D. Announcements

- Consumer Rights Meeting
  Today at 12:30 p.m.
- Rally for Recovery
  September 9th • Ocean Springs
- Trauma Informed Care Conference
  September 26th–29th • Jackson Convention Complex

D. Other Public Comments

None

IV. Scheduling of Next Meeting/Topics

Topics:

- NAVIGATE

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, November 2, 2017 at 10:00 a.m.

V. Adjournment

The meeting was adjourned.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Tanya Bradley	State Employees	MS Department of Education	P.O. Box 771 Jackson MS, 39205-0771	tbradley@mdek12.org
Rachel Chandler	State Employees	MS Insurance Department	P.O. Box 79 Jackson MS, 39205 PH: 601-359-5537	rachel.chandler@midm.s.gov
Mark Chaney	Others (Not State employees or providers)	MS A&D Advisory Council	7070 Hwy 80 Vicksburg MS, 39180 PH: 601-638-4784	
Shawn Clark	Providers	VA medical Center (serves on MS A&D Advisory Council)	1500 East Woodrow Wilson Jackson MS, 39216 PH: 601-362-4471	
Amanda Clement	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	614 Eatonville Road Hatteisburg MS, 39401 PH: 601-582-8515	
Meridith Clemmons	Others (Not State employees or providers)	MS CAN Field Care	5 Colebay Road Hattiesburg MS, 39402 PH: 800-548-6549	meredith.clemmons@uhc.com
David Connell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	44 Bates Lane Hattiesburg MS, 39402 PH: 601-520-1096	
Chelsea Crittle	Providers	Central MS Planning and Development District	1170 Lakeland Drive Jackson MS, 39296 PH: 601-981-1516 FX: 601-981-1515	ccrittle@cmpdd.org
Kay Daneault	Providers	Mental Health Association	4803 Harrison Circle Gulfport MS, 39507 PH: 228-864-6274 FX: 228-864-1310	kay@msmentalhealth.org
Debbie Dobbins	Providers	Southern Christian Services for Children and Youth	800 E. River Place Jackson MS, 39056 PH: 601-354-0983	scscydebbie@att.net
Annette Giessner	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	238 Sawbridge Drive Ridgeland MS, 39157 PH: 601-853-0815	bgeorgeG@att.net
Maxie Gordon	Providers	MS Psychiatric Association	University of MS Medical Center Jackson MS, 39216 PH: 601-984-1000	maxiegordon@bellsouth.net
			P.O. Box 1698	

Lavonda Hart	State Employees	MS Department of Rehabilitation Services	Jackson MS, 39215 PH: 601-853-5270 FX: 601-853-5205	lhart@mdrs.ms.gov
Ronney Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	VA Medical Center	211 Samuel Road Madison MS, 39110	ronney henderson@va.gov
Joe Kinnan	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health Association	204 Greenwood Place Hattiesburg MS, 39402 PH: 601-264-6994	jekin@comcast net
Sandy Kinnan	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health Association	204 Greenwood Place Hattiesburg MS, 39402 PH: 601-264-6994	jekin@comcast.net
Toniya Lay	Federally Recognized Tribe Representatives	MS Band of Choctaw Indians	210 Hospital Circle Choctaw MS, 39350 PH: 601-390-6291	Toniya.lay@choctaw.org
Mark Leiker	State Employees	Division of Medicaid	550 High Street Jackson MS, 39201 PH: 601-359-6114 FX: 601-576-4163	mark leiker@medicaid.ms.gov
Tara Manning	Parents of children with SED	MS Families As Allies for Children's Mental Health, Inc	331 Bounds Street Jackson MS, 39206 PH: 601-981-1618	tmanning@msfaacmh.org
Harriette Mastin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	11880 Highway 61 South Vicksburg MS, 39180 PH: 601-630-9470	Mastin8@juno.com
Sandra McClendon	State Employees	Division of Family and Children's Services, MDHS	750 N State Street Jackson MS, 39202 PH: 601-359-4667 FX: 601-359-4340	sandra mcclendon@mdhs.ms.gov
Janette McCrory	State Employees	Institutions of Higher Learning	3825 Ridgewood Road Jackson MS, 39211 PH: 601-432-6486 FX: 601-432-6225	jmccrory@ihl.state.ms.us
Ben Mokry	State Employees	MS Home Corporation	735 Riverside Drive Jackson MS, 39202 PH: 601-718-4611	ben.mokry@mshc.com
Ekoko Onema	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	111 Woodward Court Jackson MS, 39212 PH: 980-210-0722	ekokomonique@gmail.com
Elaine Owens	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	105 Garden View Drive Brandon MS, 39047 PH: 601-576-6869	eowens@mdah.state.ms.us
Coreaner Price	Parents of children with SED	MS Families as Allies	5166 Keele Street Jackson MS, 39206 PH: 601-981-1618	cprice@msfaacmh.org
John Quinos	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	2800 19th Ave Gulfport MS, 39501 PH: 228-326-9720	johnaq59@gmail.com

Kim Richardson	State Employees	MS Bureau of Investigation	2200A Highway 35 North Batesville MS, 38606 PH: 662-563-6477 FX: 662-563-6493	krichardson@dps.ms.gov
Tonya Tate	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	152 Edward Owens Drive Terry MS, 39170 PH: 601-954-2421 FX: 601-849-4733	ttate@bellsouth.net
Tameka Tobias	Others (Not State employees or providers)	NAMI	2618 Southerland Street Jackson MS, 39216 PH: 601-899-9058 FX: 601-956-6380	tsmith@NAMIS.org
Larry Waller	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	11085 Old Delalb Scooba Road Scooba MS, 39385 PH: 662-476-8035	tlwaller@bellsouth.net
Nancy White	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	332 Becker Street Brookhaven MS, 39601 PH: 423-331-1243	Godbold52@att.net
Harold White	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	332 Becker Street Brookhaven MS, 39601 PH: 423-331-1243	Hwhite52@att.net
Scott Willoughby	Providers	South MS State	South Mississippi State Hospital Purvis MS, 39475 PH: 601-794-0241	swilloughby@smsh.state.ms.us
Melody Worsham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	6474 Florence Road Biloxi MS, 39523 PH: 228-864-6274 FX: 228-864-1310	melody@msmentalhealth.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**35**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	9	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	**20**	**57.14%**
State Employees	8	
Providers	6	
Vacancies	1	
Total State Employees & Providers	**15**	**42.86%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**1**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Council members receive information on the application instructions for the draft and final report provided by SAMHSA. The process to make a Draft Plan available for review by the Council and the public has proceeded along timelines to allow sufficient time for public review and comment in compliance with the federal submission timeline. The State Plan Draft was presented to the Council at the August meeting. The comment period for the State Plan Draft was August 7, 2017, through August 28, 2017. The Council had the opportunity for review of the FY 2018-2019 State Plan Draft during that time. The MS Department of Mental Health Community Mental Health Services FY 2018-2019 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission. The MS Department of Mental Health Community Mental Health

Services FY 2018-2019 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission

Footnotes:

The CMHC Director for Region 4/Timberhills Mental Health Health Services retired as of July 1, 2017 He served as a "Provider" on the Council.

Although not required, representation from the Mississippi Department of Health is also currently vacant.