Mississippi

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/25/2021 5.49.52 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 809399926

Expiration Date

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

Agency Name Mississippi Department of Mental Health

Organizational Unit Bureau of Community 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 Wendy

Last Name Bailey

Agency Name Mississippi 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 wendy.bailey@dmh.ms.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ○ No

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

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Mallory

Last Name Malkin

Telephone (601) 359-1288

Fax (601) 359-6295

Email Address mallory.malkin@dmh.ms.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Wendy Bailey

Signature of CEO or Designee[1]: _____

Title: Executive Director, Mississippi Department of Mental Health

Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

1) **Identify the needs and gaps of your state's mental health services in the context of COVID-19.**

As a result of the short turn-around time for submission of the first round of MHBG COVID-19 Relief Supplemental Funding a mechanism of provider feedback was not possible. However, a needs assessment was sent in July 2021 to all certified community mental health and substance use providers state-wide in an effort to solicit community feedback and gauge specific needs throughout the state.

The COVID-19 pandemic has generated mass infections, staggering death totals, social disruption, and economic fallout not seen since the 1918 flu pandemic. Public health experts have identified COVID-19 as the most formidable health crisis of the twenty-first century. Mississippi (MS) has experienced a significant number of COVID-19 cases and deaths. These challenges have been magnified by MS' poverty rates, pronounced health disparities, longstanding racial-ethnic stratification, and rural remoteness. These factors have long placed MS atop state rankings in negative mental health indicators. Under normal circumstances, MS faces formidable mental health (MH) adversities and co-occurring disorder (COD) problems. The COVID-19 pandemic, coupled with social distancing directives, shelter-in-place orders, and mass unemployment, has raised these threats to critical levels in the nation's poorest state.

The Mississippi Department of Mental Health (DMH) has seen an increase in the number of people contacting the agency's 24/7 Helpline. In the first half of FY21, there were a total of 5,004 calls to the DMH Helpline. At this point in FY20, there was a total of 3,015 calls to the DMH Helpline. This is an increase of approximately 66% over this time last year. There were 4,398 calls to the Mississippi Call Center for the National Suicide Prevention Lifeline in the first half of FY21. At this point in FY20, there had been 3,523 calls. This is an increase of approximately 25%. The increase in the number of people needing information and services can clearly be seen through this data.

A previous psychiatric diagnosis is a key indicator when evaluating the incidence and prevalence of the coronavirus infection (COVID-19) and its subsequent impact (Taquet, Luciano, Geddes, & Harrison, 2021). Taquet and colleagues' (2021) research suggested that even for individuals without any history of psychiatric diagnoses or mental health concerns, that there was a greater incidence of an initial psychiatric diagnoses within 90 days of their COVID-19 diagnosis. This finding would provide greater support for the expansion and strengthening of mental health

services for all residents of Mississippi as contraction of COVID-19 may result in greater psychiatric instability and symptoms that require treatment and monitoring. An international study has further supported the tenet that individuals with psychiatric disorders are at an increased risk of death and serious health conditions resulting from COVID-19 (Barcella et al., 2021). Barcella and colleagues (2021) reported that significant mental health symptoms place an individual at greater risk for the coronavirus infection, as well as other health conditions that may impact their overall prognosis in recovery of the coronavirus. For instance, those with psychiatric diagnoses are at an increased risk of pre-morbid (prior to COVID-19 contraction) health conditions such as chronic obstructive pulmonary disease (COPD), diabetes, heart disease, obesity, and substance use (Barcella et al., 2021). Of interest to note, schizophrenia and both unipolar and bipolar depression were associated with an increased risk of severe outcomes associated with the coronavirus as well as comorbid health diagnoses (Barcella et al., 2021). Treatment adherence and availability of services throughout the community is vital to reducing adverse psychiatric and health outcomes associated with the pandemic.

Social isolation and loneliness are linked to poor mental health and recent data from the Kaiser Family Foundation shows that 47% of people reported negative mental health effects from worry or stress related to COVID. According to the Kaiser Family Foundation, the COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. As of data collected through May 2021, about 3 in 10 adults in the U.S., during the pandemic, have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019. Additionally, the most recent data indicates that 25.7% of adults in Mississippi reported symptoms of anxiety and/or depressive disorder during the pandemic.

Research from prior economic downturns shows that job loss is associated with increased depression, anxiety, distress, and low self-esteem and may lead to higher rates of substance use disorder and suicide. During the pandemic, adults in households with job loss or lower incomes report higher rates of symptoms of mental illness than those without job or income loss (53% vs. 32%).

The impact of COVID-19 on the mental health of Mississippians cannot be overstated among all demographics with the number of people reporting symptoms of anxiety, depression and suicidal ideation increasing. The Mississippi Department of Mental Health has made tremendous gains in development, implementation, and expansion of crisis services and intensive community supports throughout the state. MDMH continues to focus on provision of quality, evidenced based care founded in a recovery-oriented framework for all Mississippians. MDMH continues to strive to promote a system of innovation, transformation, and enhancement of community-based services to allow Mississippians to remain in and connected to their communities during treatment of psychiatric disorders and/or crises.

The results of the state-wide needs assessment survey resulted in beneficial and insightful feedback that has advised the present supplemental funding application. In relation to the

provision of mental health services due to the COVID-19 pandemic, Mississippi can continue to address gaps and needs and increase access to services through the following: community outreach, development and maintenance of two positions devoted to crisis services (Crisis Coordinator and Director of Crisis Response Services), Crisis Response Technology and Infrastructure, an increase in funding for Purchase of Service for individuals who do not have a payor source for mental health treatment, additional monies for a Medication Assistance Fund to help those who do not have funds to pay for needed medication for their SMI, expansion/continuation of Supported Employment, continuation of Certified Peer Support Specialists (CPSS) at Crisis Stabilization Units, expansion of First-Episode Psychosis programming in the state, continuation of Safe Homes, and strengthening and expansion of service provision for school-aged children as it relates to mental, emotional, and social well-being.

References

Taquet, M., Luciano, S., Geddes, J. R., & Harrison, P. J. (2021). Bidirectional associations between COVID-19 and psychiatric disorder: retrospective cohort studies of 62 354 COVID-19 cases in the USA. *The Lancet Psychiatry*, *8*(2), 130-140.

Barcella, C. A., Polcwiartek, C., Mohr, G. H., Hodges, G., Søndergaard, K., Niels Bang, C., ... & Kragholm, K. (2021). Severe mental illness is associated with increased mortality and severe course of COVID-19. *Acta Psychiatrica Scandinavica*.

2) Describe how your state's spending plan proposal addresses the needs and gaps.

- **Crisis Services (10% Set-Aside)** – **Budget Total - $1,305,228**
  The 10% Crisis Set-Aside will be utilized to address the need for a one-number call center for Mobile Crisis Response and the implementation of the 988 initiative. More details in Question 3.

    - **<u>Director of Crisis Response – $191,591.92</u>**

      The Department is requesting a full-time permanent employee to serve as the Director of Crisis Response. This employee will oversee the development and maintenance of a statewide crisis response plan for individuals experiencing mental health, substance use, or other related behavioral health crises and will oversee the development of policies and procedures for mobile crisis response teams for the state. The incumbent will ensure that enrollment, diversions, access to care, productivity, and quality of care metrics are met by the community providers. This position is responsible for reporting on metrics and budgeting activities, develop budgets/grants and program plans, and provide guidance, support, and professional development and training to Community Mental Health Centers. The director will represent the program to external

partners such as police departments, local governments, and community mental health providers.

- **Crisis Response Technology and Infrastructure & Crisis Coordinator - $1,113,636.08**

  The Department is working to improve the coordination of services via technology for a more effective behavioral health crisis continuum. As the agency works to implement 988 and mobile crisis response, new technology to assist in the delivery of services and coordination of care is needed. Funds will be used for technology and infrastructure to improve access, coordination, and delivery of services. The department is working to develop a crisis call center as well as implement 988. In the future, the state may merge the two phone numbers, but funds are needed to create the infrastructure to support a crisis care control center. Plans are fluid in this category, but the primary focus would be on the following:

  - **Real-Time Bed Registry**
  - **Electronic Record and Dispatch Technology**
  - **Telecom System**
  - **Electronic Crisis System Services Access Dashboard**
  - **Chat and Text Technology**
  - **Crisis staff Hardware**
  - **Other Hardware and Connectivity**
  - **Analytics and Reporting Tools**
  - **Call Center Disaster Continuity Tools**

  As the agency determines the best response system for the state, these funds would either be used by the Department of Mental Health to create a crisis call center or to request quotes from providers to provide a crisis response system.

  The Department of Mental is also requesting a Crisis Coordinator position to assist with building relationships with providers throughout the state to create closer linkages among crisis service providers, crisis hotlines, community mental health centers, emergency departments/hospital systems, law enforcement, peer support specialists, housing authorities, etc. The incumbent will collaborate with providers throughout the state to move crisis care initiatives forward.

- **Adult Services – Budget Total – $5,793,969**
  - **Purchase of Service – Budget Total - $1,700,000.00**

    DMH will provide funding for individuals, who have no ability to pay, to access to mental health services. Individuals must be age 18 and over, with serious mental

illness that results in functional impairment which substantially interferes with, or limits one or more major life activities. This funding is not intended to provide ongoing services for individuals who do not qualify for benefits.

- **Medication Assistance Fund – Budget Total - $400,000.00**
  DMH will create a Medication Assistance Fund to be used to provide medication access to people in the community who have a SMI and who are receiving services through a CMHC who could not otherwise access prescribed medication that they need to avoid a serious risk of hospitalization. The fund can be accessed for a person once the CMHC has provided documentation that the CMHC has: 1) assisted the person in initiating the enrollment process for Medicaid, and/or 2) submitted a request to enroll the person in a prescription assistance program. Persons will be eligible for medication assistance for a period of 90 days. The 90-day eligibility period may be renewed, for up to one year, upon a showing by the requesting CMHC that attempts to secure alternative medication access are ongoing and have not yet been successful.

- **Supported Employment – Budget Total - $360,000.00**
  DMH currently funds four evidenced-based Supported Employment Programs of Individual Placement and Support (IPS) model. An addition three IPS sites have been added in FY 22 in Regions 4, 8 and 9. Supported Employment helps people diagnosed with mental illnesses secure and keep employment and begins with the idea that every person with a serious mental illness can work competitively in the community. With this funding, DMH will continue to support and foster expansion of Supported Employment services by add an additional three IPS sites and/or provide additional funding to existing sites to expand their outreach and impact.

- **Certified Peer Support Specialists at CSUs – Budget Total - $650,000.00**
  DMH has a statewide Certified Peer Support Special (CPSS) Program. With this funding, DMH will provide a continuation of funds to support Certified Peer Support Specialists (CPSS) employed at each of the 13 Crisis Stabilization Units (CSUs) statewide. In FY20, Mississippi had 271 CPSS employed within the state's mental health system. CSUs offer time-limited residential treatment services to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient treatment. SAMSHA's National Guidelines for Behavioral Health Crisis Care recommends having peer support integrated into crisis programs such as mobile crisis and crisis stabilization. Peer support workers

often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

- **Diversion Coordination – Budget Total - $1,883,969.00**
  DMH will offer funding to each CMHC to develop a diversion coordination team to prevent unnecessary state hospital admissions and re-admissions and refer appropriate individuals to the applicable intensive community supports (i.e., PACT, ICORT, ICSS). This will support individuals, who do not meet civil commitment criteria, remaining safely in their community with services wrapped around them through the community mental health center. The diversion coordination team can be developed within an established team (e.g., intake, admissions, etc.) or a new team/staff position can be developed.

- **Technical Assistance/Evidenced-Based Training – Budget Total - $300,000**
  DMH will enhance the delivery of community-based services and supports to help Mississippians avoid institutionalization and remain in their communities. This will include technical assistance and training for any applicable staff, including MCERT staff, focused on trauma, self-harming, suicide and homicide-risk assessments, diversion coordination, and de-escalation strategies, as well as expanded Crisis Intervention Training (CIT) for law enforcement officers.

- **Children and Youth Services – Budget Total – $4,026,317**
  - **First Episode Psychosis 10% Set-Aside – Budget Total – 1,305,228**
    Navigate is an evidence-based program that assists Mississippians, 15-30 years of age, who have experienced their first episode of psychosis. Services are delivered by Coordinated Specialty Care Teams, which provide early intervention and recovery-oriented services that have been shown to improve outcomes in youth and young adults who are at risk for serious mental illness. Interventions include intensive case management, individual or group therapy, supported employment, education services, family education and support, medication management, and peer support services. This approach bridges existing resources and eliminates gaps between adolescent, and adult programs. DMH funds the program at Life Help, Hinds Behavioral Health Services, Warren Yazoo Behavioral Health, and Region 8 Mental Health Services, which began offering Navigate in FY19. In FY20, the program served 63 youth/young adults. With this funding, DMH will add two additional Navigate programs in the state. An RFP will be issued to all providers with a Navigate Program to expand outreach and service provision for those enrolled in the program. Additionally, an RFP will be issued to all providers who

do not currently have a Navigate Program to develop and implement in their community. The RFP will specify an allocation of 20% of budget toward the Navigate's Program outreach campaign with focus on marketing and recruitment.

- **Safe Homes for Children and Adolescents – Budget Total - $500,000.00**
  DMH will provide continuation of funds for the three (3) four-bed safes homes for youth that were added during FY 22. These safe homes provide placement for youth ages 13-18 with serious emotional disturbances. With the addition of these safe homes, Mississippi will have a total of five (5) safe homes. Currently, one safe home is operated by Region 2 CMHC/Communicare, and Region 9 CMHC/Hinds Behavioral Health Services operates the Children's Crisis Stabilization Unit (CSU). Two homes will serve females, and two will serve males. The CSU operated by Region 9 CMHC is a 12-bed facility that serves both males and females. These homes will support youth 24-hours per day, seven days per week who are in crisis or at risk of being in crisis. Youth admitted to the safe homes will receive Wraparound Facilitation where a team will be formed to include family, friends, or other supportive individuals to develop and implement an individualized service plan. Youth in the safe home will have access to both medical and mental health services and will receive educational services from the local school district. RFPs for the three (3) FY 22 safe homes are currently being reviewed and processed. DMH will utilize these funds to continue to support the implementation and service provision provided through the safe homes.

- **Mental, Emotional and Social Well-being in School-Aged Youth – Budget Total 2,826,317.00**
  The COVID-19 pandemic has greatly affected the mental, emotional, and social well-being and health of school-aged youth 5-18 years and their families. The last two years have been overcome by frequent and abrupt changes in routine and expectations. Consequently, DMH will seek proposals targeting the school-aged population and focusing on programmatic support and development, including, but not limited to, continuation of socioemotional learning curriculums, mental health prevention and treatment in school settings, utilization of psychology training-clinics throughout the state to expand outpatient therapy and assessment services for indigent populations, evidenced-based treatment for trauma and related sequelae (e.g., problematic sexualized behaviors, posttraumatic stress disorder, sleep dysfunction etc.), evidenced-based treatment for families and youth focused on anxiety and depression, as well as

an emphasis on juvenile justice populations with mental health diagnoses or significant mental health symptoms/impairment.

- **Technical Assistance/Evidenced-Based Training** – **Budget Total - $200,000.00**
  DMH will enhance the delivery of community-based services and supports to help Mississippians avoid institutionalization and remain in their communities. This will include technical assistance and training focused on trauma, juvenile justice, self-harming, suicide and homicide-risk assessments, diversion coordination, and de-escalation strategies, as well as other evidenced based treatment and programs for children and youth.

- **Community Outreach Initiative – Budget Total - $1,000,000**

  Public awareness and communication regarding mental health services are vital parts of the Mississippi Department of Mental Health's mission of supporting a better tomorrow in the lives of the state's citizens. Mississippi has made great strides in providing community-based mental health and behavioral crisis services throughout the state; however, widespread knowledge of these services is limited, and the state recognizes this gap in the mental health services continuum. Mental Health America in its 2020 Access to Care Data reports that 57.2% of adults with a mental illness did not receive any treatment during the previous year, leaving the mental health needs of more than 26 million individuals untreated. Mississippi was ranked 37 nationally in this measure. The National Council for Mental Wellbeing reports that many people who experience mental health problems delay seeking treatment by ten years, if at all. According to a study conducted by the Cohen Veterans Network and National Council for Behavioral Health in 2018, while most Americans do try to seek out treatment, there also is a large portion (29%) of the population who have wanted to but did not seek treatment for themselves or loved ones, in part due to not knowing where to go if they needed services. Furthermore, younger Americans are less sure about resources for mental health services compared to older generations. Promoting awareness of services and education regarding mental health can undoubtedly play a large part in improving Mississippians' access to care, particularly in rural and underserved populations and areas. Funds would be used for a comprehensive information dissemination and education campaign that will target adults with serious mental illnesses, children with serious emotional disturbances, and their families and friends. The primary goals are to heighten public awareness of mental health services in Mississippi, while decreasing the stigma of reaching out for help. The agency will work with a professional consultant to develop key messaging, educational and awareness collateral, and execute a marketing and media plan that maximizes the impact of the services available in communities around the state. The promotion of services available

to Mississippians in need will support the behavioral health crisis continuum by educating the public of services available and how to access those services. The campaign will focus on disseminating information regarding Mississippi's crisis response system, including 988 and mobile crisis teams, crisis stabilization units, and emergency crisis services; intensive community support services, including Programs of Assertive Community Treatment (PACT) teams and Intensive Community Outreach Recovery Teams (ICORT); supported living services; peer support services; and services provided by community mental health centers. This outreach campaign will support the behavioral health crisis continuum by educating the public of services available and how to access those services. It will focus on disseminating information regarding Mississippi's crisis response system, including 988 and mobile crisis teams, crisis stabilization units, and emergency crisis services; intensive community support services, including Programs of Assertive Community Treatment (PACT) teams and Intensive Community Outreach Recovery Teams (ICORT); supported living services; peer support services; and other services provided by community mental health centers.

- **Administrative – Budget Total - $621,537**

3) Describe how the state will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The 5% crisis services set-aside applies to these funds.

The 10% Crisis Set-Aside will be utilized to address the need for a one-number call center for Mobile Crisis Response and the implementation of the 988 initiative. DMH received the planning grant from Vibrant Emotional Health and the state is in the early stages of developing a roadmap for 988 implementation. A planning coalition has been formed and a consultant selected to assist in developing the 988 implementation plan. Mississippi has two Lifeline call centers. Although the strategic plan for 988 implementation has not been developed, DMH foresees the two Lifeline centers continuing to answer 988 calls and DMH answering crisis calls that may not elevate to the Lifeline. All three entities will work hand-in-hand to provide crisis response, intervene in emergencies, make referrals, and ensure callers receive appropriate and timely assistance. The crisis set-aside funding will be utilized to begin implementation of 988 in our state and associated logistical considerations related to 988. The full implementation of 988 is anticipated for July 2022.

While mobile crisis services are operational statewide, there are still areas of improvement needed. MDMH proposes to utilize the set aside of block grant funds to expand and support our statewide toll-free phone number so that all crisis calls will be received in one location;

documented; and triaged to the appropriate MCeRT. The funding will provide the mechanism to address logistical and management considerations, such as development and inclusion of a Crisis Coordinator and Director of Crisis Response, as well as the technology and infrastructure to support the needs of the crisis teams and larger community.

Currently, individuals in crisis can access assistance by contacting one of 15 different phone numbers. This is due to each of the CMHCs operating individual, toll-free numbers for each of their catchment areas. DMH believes that one toll-free crisis line would provide easier access to crisis services for Mississippians in need. Additionally, it would allow our state to streamline crisis data by entering the data into one central database. This will help DHM make informed decisions about crisis services and ensure crisis response and follow up is consistent statewide. DMH currently operates an information/referral, crisis "helpline".

While Mississippi has regional crisis call services offering real-time access to a live person every moment of every day for individuals in crisis as recommended by the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, this funding will help establish a call hub and implement 988 in our state. The one-number staffed call hub/crisis call center will be able to provide telephonic crisis intervention services to all callers and provide quality coordination of crisis care in real-time by connecting with statewide Mobile Crisis Response Teams. This funding will also address the National Guidelines through the implementation of 988.

4) **Explain how your state plans to collaborate with other departments or agencies to address the identified needs.**

Collaboration will include partnerships for funding opportunities with the 13 Community Mental Health Centers across the state for a variety of services and supports listed above. The regional CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors from their respective service areas. The 13 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. DMH is responsible for certifying, monitoring, and assisting CMHCs. The CMHCs are the primary service providers of outpatient community-based services in the state to adults and children with mental illness, substance use, and intellectual and/or developmental disabilities. Collaboration will also include partnerships with current and prospective community providers and schools for greater access to care; Collaboration with the 988 Planning Coalition, which includes representatives from CMHCs, hospitals, providers, other state agencies, and family members, will be a part of the 10% crisis set aside funding. A wide range of collaboration among other state agencies, CMHCs, planning coalition, and more will address the identified needs in this proposal.

State Information

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

Fiscal Year 2022

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

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Wendy Bailey

Signature of CEO or Designee[1]:

Title: Executive Director

Date Signed: 08/05/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State of Mississippi

TATE REEVES
Governor

August 16, 2021

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

Dear Ms. Crocker:

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

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

Sincerely,

Tate Reeves
Governor

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

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 Wendy Bailey
Title Executive Director
Organization MS Dept. of Mental Health

Signature: [signature] Date: 8/5/21

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

Wendy Bailey

Title

Executive Director

Organization

Mississippi Department of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Step 1: Assessment of the Strengths and Needs of the Service System

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 Central Office of the Department of Mental Health provides the overall statewide administrative functions for the programs and services that fall under the oversight of the agency. The Central Office is headed by the Executive Director with bureaus and divisions falling under the direction of the Executive Director, the Deputy Executive Director of Community Operations, the Deputy Executive Director of State Operated Programs, the Chief Financial Officer, or the Chief of Staff.

The Deputy Executive Director of Community Operations administers and monitors the delivery of community mental health and IDD services and supports. The Deputy Executive Director of Community Operations oversees the Chief Clinical Officer of Behavioral Health Services, the Chief Clinical Officer of Community IDD Services, and the Bureau of Certification and Quality Outcomes within the Central Office.

Behavioral Health Services is under the direction of the Chief Clinical Officer for Behavioral Health Services and is responsible for planning, development, and supervision of an array of services and supports for children/youth and adults in the state with serious emotional disturbance, serious mental illness and substance use disorders. The Bureau is comprised of two main areas, Community Mental Health Services and Alcohol and Drug Addiction Services. The Bureau is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services 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.

Community Intellectual and Developmental Disabilities is under the direction of the Chief Clinical Officer of Community IDD Services and is responsible for planning, development, and supervision of an array of community services for people in the state with intellectual and developmental disabilities which includes the ID/DD Waiver Program and the IDD Community Support Program. 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 Certification and Quality Outcomes is responsible for maintaining the safe provision of high-quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes two divisions, The Division of Certification and the Division of Professional Licensure and Certification (PLACE).

The Deputy Executive Director of State Operated Programs oversees the agency's state operated IDD programs and behavioral health programs. The Director is responsible for planning, development and supervision of an array of services for people in the state with mental illness and intellectual and developmental disabilities. The Department administers and operates state behavioral health programs and a specialized behavioral health program for youth. These programs serve designated counties or service areas and offer community living and/or community services. The Department also operates regional programs for persons with intellectual and developmental disabilities and a specialized program for adolescents with intellectual and developmental disabilities.

Administrative functions of the Central Office include: the Bureau of Human Resources, which is responsible for employment and workforce development; the Office of General Counsel, which is responsible for all legal matters and oversees Incident Management; the Chief of Staff which is responsible for the Division of Outreach and Training for outreach efforts, public awareness campaigns, statewide suicide prevention, and trainings, the Office of Communications and Planning, which is responsible for the DMH strategic plan, internal and external communications, and media relations, and the Branch of Coordinated Care, which is responsible for promoting the integration of the components of recovery and resiliency in practice and overseeing the DMH Helpline; and the Chief Financial Officer, which is responsible for the Division of Information Systems that oversees the agency's hardware, software, and networking of computers and information technology needs, the Division of Accounting, which is responsible for accounting and finance services, and the Division of Audit/Grants, which oversees the use of grant funds, assesses quality of internal controls, and determines compliance with policies and procedures.

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, and South Mississippi State Hospital. 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 and its satellite program, South MS Regional Center, Hudspeth Regional Center, and North 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 13 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. The role of State agencies in the delivery of behavioral health services is addressed in: Support of State Partners.

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 Raquel Rosamond, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Region IV 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, Bolivar, Washington, Sharkey, 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 Richard Duggin, 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 Russ Andreacchio, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne,	A Clear Path: Southwest Mississippi Behavioral Health

Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	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, Pearl River, Stone, Harrison, Hancock	Pine Belt Mental Healthcare Resources Mona Gauthier, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
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

- A four-year System of Care Expansion and Sustainability Agreement will end September 30, 2021 where two local community mental health center regions implemented the program in five counties that targeted underserved children and youth (ages 3- 21) who are involved in the child welfare system and /or the juvenile justice system, referred to "crossover youth", and those at risk for becoming crossover youth, and their families. Crossover XPand provided evidence based practices; training for professionals, youth and their families; and, resources and informal supports to youth enrolled in the program. DMH partnered with two local CMHCs in the spring of 2021 and applied for another System of Care Expansion Grant through SAMHSA to continue the expansion of System of Care principals and services along the coastal region of the state.

- 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. On the local level, the DMH provides flexible funding to 55 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). Training was completed in July 2021 on MRSS for the Mobile Crisis Emergency Response Teams to provide strategies for team members to effectively deescalate, stabilize, and improve treatment outcomes for our children and youth in crisis.

- The DMH continues to fund ten CMHCs for 14 Juvenile Outreach Programs to provide 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. In FY22, a Youth Mental Health Court Program, the first of its kind, will be operated by a local CMHC to provide an array of services to youth entering the juvenile justice system to deter future justice involvement.

- 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 2,100 children/youth annually.

- Through an initiative with NAMI MS, DMH, along with several CMHCs and input from youth, developed a specialized curriculum for Youth and Young Adults. This curriculum has been integrated into the existing Certified Peer Support Specialists training with modules specifically designed for youth/young adults such as Cultural Diversity; Youth Driven System of Care; Suicide Prevention; Self-Care; Youth Advocacy and Communication; and, Independent Living Resources.

- NAVIGATE is an evidence-based program designed to assist youth and young adults who have experienced their first psychotic episode. DMH added three (3) additional NAVIGATE teams for a total of four (4) teams located throughout the State. The NAVIGATE teams use the NIMH recommended model Coordinated Specialty Care Teams for First Episode Psychosis (FEP). The teams continue to receive ongoing training and technical assistance from the NAVIGATE consultants.

- The Interagency Coordinating Council for Children and Youth, a state level council designated to coordinate the System of Care, resumed meeting in FY21. Membership consists of the Executive Directors from the child-serving state agencies, Families As Allies, the Attorney

General, a family member of a child or youth and a youth or young adult, a local MAP team coordinator, a child psychiatrist, designated by the Mississippi Psychiatric Association, an individual with expertise in early childhood education, a representative from an advocacy organization, and a faculty member or dean from a Mississippi university that trains professionals who work in the Mississippi Statewide System of Care.

- Youth in crisis are now able to receive services at the Ruth Wilson Children's Crisis Stabilization Unit operated by Region 9 CMHC. Youth experiencing a mental health crisis receive a psychological evaluation, medication monitoring, mental health treatment and referral to an appropriate level of care. The 12-bed facility serves both male and female youth ages 11-18.

- Youth Mental Health First Aid trainings are provided 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. A federal grant from the Substance Abuse and Mental Health Services Administration in 2018 enabled DMH to offer mental health training and education to schools and educators throughout the state. Mississippi's Mental Health Awareness Training Project increased mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH has partnered with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH provides training in Mental Health First Aid for Youth to educators and parents.

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 Intensive Community Outreach Teams (ICORT) and Wraparound Facilitation to additional providers in the state to prevent the need for acute care and/or referrals to Psychiatric Residential Treatment Facilities.

- 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 three 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 nine (9) 16–bed CSUs and four 8-bed CSUs 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.

- In addition to Mississippi State Hospital and East Mississippi State Hospital, 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 Bureau of Behavioral Health 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, ICORT and MCeRT.

- The Bureau of Behavioral Health 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 Behavioral Health 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.

- Supported Employment Sites are offered in Regions 1,2,3,4,6,7,8,9,10,11,12,14 and 15 with a goal of offering supported employment to people with serious mental illness.

- 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 DMH will resume Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members once the pandemic subsides and distancing orders are lifted. ASIST can only be conducted face-to-face and is a 2–day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.

- Mississippi has ten (10) Programs of Assertive Community Treatment Teams (PACT) that serve the following counties: Region 3 (serves Lee and Itawamba Counties), Region 4 (serves DeSoto, Prentiss, Alcorn, Tippah, and Tishomingo Counties), Region 6 (serves Leflore, Holmes, and Grenada Counties), Region 8 (serves Madison and Rankin Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest, Perry, Harrison and Hancock 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.

- Mississippi has 16 Intensive Outreach and Recovery Teams (ICORT) that serve the following counties: Region 1(Coahoma, Quitman, Tallahatchie, Tunica) Region 2 (serves Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha), Region 6 (Washington, Bolivar), Region 7 (Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston), Region 8 (Copiah, Lincoln, Simpson), Region 9 (Hinds), Region 10 (Clarke, Leake, Newton, Smith, Scott), Region 11 (Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson), Region 12 (Covington, Jefferson Davis, Jones, Lamar, Marion, Pearl River), Region 14 (George, Jackson).

- Any county in Mississippi that is not served by a PACT or ICORT team is served by Intensive Community Support Specialist services.

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, corrections officers, volunteer fire departments and first responders. The DMH makes grant funding available to the Lauderdale County Sheriff's Department to provide training to law enforcement to facilitate the establishment of Crisis Intervention Teams (CIT) in the state. Additionally, DMH provides funding through a SAMHSA grant to Region 12, Pine Belt Mental Heatlhcare Resources, for CIT expansion in the southern half of 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 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 and the University of South Florida. 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.

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 Spectrum Center in Hattiesburg, is a resource center and an advocate for the LGBTQ+ community, partners with the SOC site in Hattiesburg and provides training to the staff and community

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. 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. Through our partnership with the National Guard, the Department of Mental Health is a frequent presenter of Shatter the Silence: Suicide-The Secret You Shouldn't Keep at Yellow Ribbon events throughout the state that reach thousands of returning soldiers and their family members. The presentation is customized to the audience and teaches mental health awareness, risk factors and warning signs for suicide, and resources available to help a person in suicidal crisis.

In March, 2021 Mississippi was invited to be a part of the VA/SAMHSA's Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF). Mississippi was one of 8 states invited to participate in the challenge and will join 27 other states who have completed the challenge. The Department of Mental Health's Executive Director, Wendy Bailey, was named as Mississippi's Team Leader. Team members include representatives from:

- The Mississippi Department of Mental Health
- The Mississippi National Guard
- Mississippi Veterans Affairs
- G.V. Sonny Montgomery VA Medical Center
- Mississippi Attorney General's Office
- The U.S. Department of Veterans Affairs
- Mississippi State University Department of Psychology and Extension Services
- Leadership from veteran, military family, and caregiver organizations
- Private sector providers and peer support specialists

The purpose of the challenge is to develop and implement state-wide suicide prevention best practices for Service Members, Veterans, and their Families (SMVF), using a public health approach. The objectives of the challenge are to:

i. Implement promising, best, and evidence-based practices to prevent and reduce suicide.
ii. Engage with city, county, and state stakeholders to enhance and align local and state-wide suicide prevention efforts.
iii. Understand the issues surrounding suicide prevention for SMVF.

iv. Increase knowledge about the challenges and lessons learned in implementing best policies and practices by using state-to-state and community-to-community sharing.
v. Employ promising, best, and evidence-based practices to prevent and reduce suicide at the local level.

Team Mississippi is in the process of writing a strategic plan addressing three priority areas which will help guide Mississippi's efforts to prevent suicide among service members, veteran's and their families in the years to come:

Priority Area 1: Identifying SMVF and Screening for Suicide Risk
Priority Area 2: Promoting Connectedness and Care Transitions
Priority Area 3: Lethal Means Safety and Safety Planning

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 13 community mental health center regions. CIT teams are located in Desoto County, Jones County, Lauderdale County, Lee County, Layfette County, Pearl River County, Forrest County, Lamar County, Pike County, and Harrison County.

Crisis Stabilization Units
The DMH funds nine (9) 16–bed CSUs and four 8-bed CSUs 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. In addition, Supervised and Supported Housing provides mental health services in group homes for individuals with SMI that are staffed 24 hours and apartments that are owned or leased by the CMHC and then re-rented to their clients with ongoing visits and support from CMHC staff.

PACT Teams
Mississippi has ten Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee and Itawamba Counties), Region 4 (serves DeSoto, Alcorn, Tippah, Tishomingo, and Prentiss Counties), Region 6 (serves Leflore County, Holmes County, and Grenada County), Region 8 (serves Madison and Rankin Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest, Perry, Harrison, and Hancock Counites), 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.

ICORT
Mississippi has 16 Intensive Outreach and Recovery Teams (ICORT) that serve the following counties: Region 1(Coahoma, Quitman, Tallahatchie, Tunica) Region 2 (serves Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha), Region 6 (Washington, Bolivar), Region 7 (Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston), Region 8 (Copiah, Lincoln, Simpson), Region 9 (Hinds), Region 10 (Clarke, Leake, Newton, Smith, Scott), Region 11 (Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson), Region 12 (Covington, Jefferson Davis, Jones, Lamar, Marion, Pearl River), Region 14 (George, Jackson).

Supported Employment
Supported employment services are offered at every CMHC 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. Currently, in addition to the 4 pilot sites initially funded, supported employment is now being provided in regions 1,2,3,4,6,8,9,11,14, and 15. Regions 4,8, and 9 will become IPS Sites in FY22.

Older Adults
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 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. 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 13 of our CMHCs.

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 13 CMHCs.

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 in September 2020 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 2019 is 364,729. Mississippi remains in the group of states with the highest poverty rate (24.9% 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 2019 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 40,071 – 47,356

- 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 25,500 – 32,785

Adults

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2020 was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi in 2019. URS Table 1 reports that there are 2,263,513 adults in Mississippi (ages 18 years +). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2019, ages 18 years and above, is 122,230 with a lower limit estimate of 83,750 and an upper limit estimate of 160,709.

The following table shows the number of adults (age 18 and above) and children (17 and below) who received mental health services through the public community mental health system during FY 2021 (DMH Data Warehouse, FY 2021). This data excludes the number of individuals who received services in the private sector or in Mississippi's six (6) state operated behavioral health programs.

State Fiscal Year	Under 18	18 and older
FY 2021	24,473	82,280

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 13 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 Interagency Coordinating Council for Children and Youth (ICCCY), 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 ICCCY was enacted into law as the coordinating entity to oversee the system of care for children's mental health in Mississippi in 2001 through legislation, and in 2010 the legislature passed HB 1529**,** which expanded its membership and further defined its duties. The ICCCY is designated to meet twice yearly to coordinate Mississippi's System of Care. The membership consists of: State Superintendent of Public Education; Executive Director of the Mississippi Department of Mental Health; Executive Director of the State Department Health; Executive Director of the Department of Human Services; Executive Director of the Division of Medicaid, Office of the Governor; (Executive Director of the State Department of Rehabilitation Services; Executive Director of Mississippi Families as Allies for Children's Mental Health, Inc.; Attorney General; a family member of a child or youth in the population named in this chapter designated by Mississippi Families as Allies; a youth or young adult in the population named in this chapter designated by Mississippi Families as Allies; a local MAP

team coordinator designated by the Department of Mental Health; a child psychiatrist experienced in the public mental health system designated by the Mississippi Psychiatric Association; an individual with expertise and experience in early childhood education designated jointly by the Department of Mental Health and Mississippi Families as Allies; a representative of an organization that advocates on behalf of disabled citizens in Mississippi designated by the Department of Mental Health; and a faculty member or dean from a Mississippi university specializing in training professionals who work in the Mississippi Statewide System of Care designated by the Board of Trustees of State Institutions of Higher Learning.

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., and representatives from Magnolia Health, UnitedHealthcare Community Plan, and Molina Healthcare. 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 13 community mental health regions across the state.

The Executive Steering Council (ESC) acts as the Executive Council for the Mississippi System of Care Grants and other grants as approved by the ESC. The ESC provides technical assistance and guidance to the local project sites and provides leadership for the management and operation of the projects. In addition to other tasks, this committee meets monthly and ensures that effective support and technical assistance are provided to the grantees. Membership of the council includes DMH Director or designee of the Division of Children and Youth Services, Division of Alcohol and Drug Services, Bureau of Behavioral Health 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 two 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.

NAVIGATE

Coordinated Specialty Care (CSC) Teams are offered in four areas of the state for youth and young adults experiencing first episode psychosis (FEP) through an evidence-based program called NAVIGATE. Regions 6,8,9, and 15 provide an array of services to youth and young adults with FEP including individual and family therapy and education, medication management, and assistance to achieve educational and work-related goals. Team member, that provide the majority of services for these youth and young adults in the community, include a Team Leader/Family Education Clinician, an Individual Resiliency Training Clinical, a Supported Employment/Education Specialist, a Prescriber, and for most programs, a Peer Support Specialist. In FY 21, 76 youth and young adults were served through NAVIGATE.

Youth Mental Health First Aid

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 June 2017, the first group of Mental Health First Aid trainers received supplemental training. A federal grant from the Substance Abuse and Mental Health Services Administration in 2018 has enabled DMH to offer mental health training and education to schools and educators throughout the state. Mississippi's Mental Health Awareness Training Project is increasing mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH is partnering with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH provides training in Mental Health First Aid for Youth to educators and parents. In FY 21, 22 YMHFA trainings were provided. In these 22 YMHFA trainings that were offered, 189 participants were trained. In the trainings offered, there were 16 school

districts represented by participants in the trainings A staff in the Division of Children and Youth continues to maintain their certification as an ASIST trainer.

Integrated Services for Children and Youth with SED

Initiatives to Assure Transition to Adult Mental Health Services

The Bureau of Behavioral Health Services has 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.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services for transitional living programs that address 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 Crossover XPand and other System of Care programs across the State, Youth Leadership and Advocacy Councils have been developed. 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, and FFCMH annual conferences and trainings.

Support for Services for Youth with Co-occurring Disorders

DMH has implemented 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 CMHCs 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 FY 2021	
Administration Amount	$296,193
Set Aside	$622,005
Amount to be awarded	$6,220,048
Children's portion	$2,044,609
Adult portion	$2,942,241

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 M/SUD system of care 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 M/SUD system of care.
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, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Step 2: Identification of the Unmet Service Needs and Critical Gaps for Adults and Children

The expansion of community-based services is driven by DMH's Strategic Plan. DMH utilizes a goal-based strategic plan to transform the public mental health system in Mississippi. The FY21-23 DMH Strategic Plan includes three goals: To increase access to community-based care and supports through a network of service providers that are committed to a person-centered and recovery-oriented system of care; To increase access to community-based care and supports for people with intellectual and/or developmental disabilities through a network of service providers that are committed to a person-centered system of care; and To ensure people receive quality services in safe settings and utilize information/data management to enhance decision making and service delivery. The Strategic Plan is revised annually and developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan is to create a living, breathing document. The Plan was and continues to be 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 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 have been used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing have been 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, through the work of the State-

Level Interagency Case Review Team, and through SAMHSA funded initiatives in our state.

The Bureau of Behavioral Health Services used the report published by Mental Health America entitled Mental Health in America 2020– Ranking the States, to assist 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 regarding unmet service needs and gaps within Mississippi's mental health system.

According to this report, Mississippi is ranked 29th overall for prevalence of adult mental illness and rates of access to care, but more specifically, Mississippi's prevalence rates are as follows:

- The prevalence of adult mental illness in Mississippi is 19.49%. (National average: 18.57%)
- The prevalence for adults in Mississippi with serious thoughts of suicide is 4.01% (National average: 4.19%)
- The prevalence for adults in Mississippi with a mental illness that are untreated 57.7% (National average: 57%)
- The prevalence of adults in Mississippi with a mental illness with unmet treatment needs in Mississippi is 21.9% (National average: 22.3%)
- The prevalence of adults in Mississippi with a substance use disorder is 6.77% (National average: 7.68%)

The Division of Adult Services within the Bureau of Behavioral Health Services is working to address the needs and gaps noted in the statistics above through the utilization of Mobile Crisis Emergency Response Teams and Programs of Assertive Community Treatment, the development of Intensive Community Outreach Recovery Teams, and through the expansion of Crisis Intervention Teams across the state.

According to the Behavioral Health Barometer, Mississippi December 2020 Report, between 2016 - 2019, 27,000 Mississippi adolescents, ages 12 to 17 (11.3% of all adolescents) had at least one Major Depressive Episode (MDE). Statistically, Mississippi's data is lower than both the regional average (13.1%) and the national average (14.0%). Approximately 11,000 adolescents, ages 12-17, with Major Depressive Episode (41.7% of all adolescents with MDE in Mississippi) received treatment for their depression, which is similar to both the regional average (40.2%) and the national average (41.8%) during the years of 2016-2019.

During 2013–2017, the annual average prevalence of past-year SMI experienced by young adults in Mississippi (ages 18-25) was 5.7% (or 18,000), lower than both the regional average of 6.9% and the national average of 7.9%. (Behavioral Heath Barometer, 2020).

In, Mental Health in America 2020 – Ranking the States (Mental Health America, 2020) the following information is reported on Mississippi's prevalence rates compared to the national average:

- The prevalence for youth (12-17) in Mississippi with at least one Major Depressive Disorder is 11.5% or 26,000 (National average: 13.01%)
- The prevalence for youth (12-17) in Mississippi with severe major depression is 6% (National average:9.2%)
- The prevalence of untreated youth (12-17) in Mississippi with depression is 63.7% (National: 59%)
- The prevalence of youth (12-17) in Mississippi with severe depression who received some outpatient treatment is 14.9% (National average: 28.2%)
- The prevalence of youth in Mississippi with a substance use disorder is 3.5% (National average: 4.13%)

DMH has worked diligently to increase the number of qualified providers and to expand services/programs across the state for children and youth with SED. Seventeen (17) providers are certified to provide Wraparound Facilitation. In the past year, a 12-bed Children's CSU serving both males and females age 11 up to age 18 operated by a local CMHC in the central portion of the state opened and is providing crisis stabilization services. An additional CSU focusing on children and youth in the custody of Child Protection Services and children and youth who have been human trafficked is planning to open its doors in September 2020.

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 to a less restrictive environment.

Strategies to attain the goal:

Utilize Peer Bridgers now at all CSUs working in conjunction with Peer Bridgers at Behavioral Health Programs local CMHCs to develop WRAP plans to help people with serious mental illness manage their mental health challenges successfully.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Peer Bridger connections

Baseline Measurement: In FY 20, there were 5 Peer Bridgers.

First-year target/outcome measurement: 7 Peer Bridgers

Second-year target/outcome measurement: 9 Peer Bridgers

Data Source:

Data is collected by the CSUs, CMHCs, and behavioral health programs regarding number of Peer Bridgers and submitted to DMH monthly.

Description of Data:

Quarterly data collected includes number of Peer Bridgers employed by and tracked by the CSUs, behavioral health programs and the local CMHCs. Services provided by Peer Bridgers will help individuals transition back into their communities and avert future potential crises. In FY 20, 298 aftercare appointments were scheduled. Of those, 210 (70%) were attended and 88 (30%) were not. This information is reported by Regions 2, 3, and 4.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 2

Priority Area: Peer Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Utilize people with lived experience of mental illness and/or substance use and/or parent/caregivers to provide varying supports to assist others in their journey to recovery and resiliency.

Strategies to attain the goal:

Conduct outreach to stakeholders to increase the number of CPSSs Provide training and technical assistance to service providers on the Recovery Model, Person-Centered Planning, and System of Care principles. Provide training to CPSS Supervisors on recruitment, retention, and supervision of CPSSs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of CPSSs employed by DMH certified providers

Baseline Measurement: In FY 20, 271 CPSSs were employed by DMH certified providers

First-year target/outcome measurement: 280

Second-year target/outcome measurement: 288

Data Source:

Data is maintained by DMH based on submission of Verification of Employment forms to the DMH Division of Place.

Description of Data:

Data is collected quarterly from all DMH certified providers employing CPSSs. In FY 15, 36 CPSSs were employed. Five years later, in FY 20, 271 CPSSs were employed by DMH certified providers.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 3

Priority Area: Community Supports for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

Increase the number of admissions to PACT Teams, Intensive Community Outreach and Recovery Teams (ICORT), and Intensive Community Support Services (ICSS).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new admissions to PACT, ICORT, and ICSS

Baseline Measurement: In FY 20, there were 215 admissions to PACT and 115 admissions to ICORT. No baseline data has been gathered for admissions to ICSS.

First-year target/outcome measurement: 225 into PACT; 125 into ICORT; 25 into ICSS

Second-year target/outcome measurement: 235 into PACT; 135 into ICORT; 45 into ICSS

Data Source:

Quarterly data will be submitted by the PACTs, ICORTs, and providers certified to provided ICSS to the DMH Division of Adult Services.

Description of Data:

Data includes number of admissions and is submitted quarterly by the PACTs, ICORTs, and certified providers of ICSS. During FY 20, 215 people were admitted to PACT and 115 admitted to ICORT.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 4

Priority Area: Community Supports for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide funding to offer costs of mental health services to people with serious mental illness who have no payor source.

Strategies to attain the goal:

Grant funding to 13 CMHCs for Purchase of Services for people with serious mental illness who have no payor source.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In FY 20 there were 148,031 units of service provided to adults with serious mental illness who have no payor source.

First-year target/outcome measurement: Maintain the number of units of service

Second-year target/outcome measurement: Maintain the number of units of service

Data Source:

The 13 CMHCs will submit data monthly through WITS and monthly reports. This data includes the number of units of services provided through the POS grant funding allocated to the 13 CMHCs. Number of units service can only be increased with an increase in funding.

Description of Data:

Data is collected through WITS and monthly reports and submitted to DMH by the 13 CMHCs.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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 to divert individuals from more restrictive environments such as jails, hospitals, etc.

Strategies to attain the goal:

Track the number of admissions to the Crisis Stabilization Units

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions to the CSUs

Baseline Measurement: In FY 20, there were 3,525 admissions to CSUs

First-year target/outcome measurement: 3,600

Second-year target/outcome measurement: 3,675

Data Source:

Data will be submitted quarterly to DMH by the CSUs.

Description of Data:

Data submitted on a quarterly basis includes number of voluntary admissions, number of involuntary of admissions, number recommended to continue treatment at one of the behavioral health programs, and average length of stay. In FY 20, there were 172 crisis stabilization beds in the state of Mississippi and the average length of stay for CSUs in FY20 was 10.99 days.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 6

Priority Area: Crisis Services

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Divert individuals from more restrictive environments such as jail and hospitalizations by utilizing Mobile Crisis Response Teams and implementation of the new 988 toll free number.

Strategies to attain the goal:

Increase the number of contacts/calls responded to by the Mobile Crisis Response Teams and the 988 toll free number.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of contacts/calls to the Mobile Crisis Response Teams

Baseline Measurement: In FY 20, there were 36,921 contacts/calls for Mobile Crisis Response Services.

First-year target/outcome measurement: 37,000

Second-year target/outcome measurement: 37,050

Data Source:

The number of emergency calls and contacts tracked by callers to the 988 number and responded to by the Mobile Crisis Response Teams is submitted to DMH two times per year.

Description of Data:

Data regarding contacts, calls, and face-to-face visits conducted by the Mobile Crisis Response Teams is submitted twice a year by the CMHCs. In FY 20, 36,921 contacts/calls in FY20. This is an increase from 27,349 in FY19. Of the 36, 921 contacts/calls responded to by Mobile Crisis Response Teams, 20,322 were face-to-face visits. This is a slight decrease from 20,529 face-to-face visits in FY19 due to safety precautions taken as a result of COVID-19.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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

Strategies to attain the goal:

Ensure that people with serious mental illness housed as a result of supportive housing 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 conducted; number of individuals maintained in supportive housing

Baseline Measurement: In FY 20, In FY20, a total of 258 people were housed with CHOICE housing vouchers. 353 people were assessed during FY 20.

First-year target/outcome measurement: 260 housed; 360 assessed

Second-year target/outcome measurement: 264 housed; 365 assessed

Data Source:

Data will be submitted quarterly by the CMHCs operating CHOICE programs. CHOICE programs are available in all CMHC regions.

Description of Data:

Data will be submitted to DMH quarterly by the 13 CMHCs. Of the 258 housed, Only 6 had to be admitted to a state hospital for treatment. 353 people out of 426 referrals were assessed during FY20. The 73 not assessed were either too violent, did not qualify for CHOICE, or could not be located after referral. This data is are reported by Mississippi United to End Homelessness and Open Doors Homeless Coalition. The number changes daily due to clients discharging. A variety of services are provided to individuals in supportive housing including outpatient services, peer support, PACT, physician services, community support services, intensive case management, and/or psychosocial rehabilitative services.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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

Strategies to attain the goal:

Technical assistance will be provided to MAP Team coordinators regarding outreach to increase participation by identified agencies as requested and/or needed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of representatives participating on MAP Teams from CPS, school districts, and juvenile justice

Baseline Measurement: In FY20, 463 representatives from CPS, school districts and youth courts participated in MAP Team meetings

First-year target/outcome measurement: 768

Second-year target/outcome measurement: 473

Data Source:

Data, including local partners present at monthly MAP Team Meetings are submitted quarterly to DMH by the MAP Team Coordinators.

Description of Data:

Local partners sign in each monthly meeting at the local level MAP Teams by name and group and/or agency affiliation. Quarterly reports are submitted to DMH by MAP Team Coordinators that include representation data as well number served, referral sources, etc. There were 463 representatives from Child Protection Services, local school districts, and youth courts participating in MAP team meetings by the end of FY20.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children and youth served by Wraparound Facilitiation

Baseline Measurement: In FY 20, 2,080 children and youth received Wraparound Facilitation

First-year target/outcome measurement: 2,100

Second-year target/outcome measurement: 2,120

Data Source:

The Mississippi Wraparound Institute located at the University of Southern Mississippi submits quarterly data to DMH which includes the number of children and youth served by Wraparound Facilitation.

Description of Data:

In FY 20, 16 providers were certified by DMH to provide Wraparound Facilitation in Mississippi. The Mississippi Wraparound Institute employs nationally certified Wraparound Facilitation coaches to provide training and support to certified providers of the service. Quarterly data submitted by MWI includes number diverted from more restrictive placements/services, number transitioned to Wraparound from more restrictive placements/services, number of facilitators trained, and number served by Wraparound Facilitation.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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 successfully at home, in a work setting, and in the community through a Coordinated Specialty Care Team.

Strategies to attain the goal:

Continue the use of an evidence-based program for youth and young adults experiencing FEP

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults experiencing FEP served through NAVIGATE

Baseline Measurement: In FY 20, 63 youth and young adults experiencing FEP were served through NAVIGATE

First-year target/outcome measurement: 68

Second-year target/outcome measurement: 73

Data Source:

Four NAVIGATE Programs/Coordinated Specialty Care Teams (Regions 6,8,9, and 15) submit quarterly data to DMH.

Description of Data:

Quarterly data submitted to DMH includes number of youth and youth adults experiencing FEP served, number of new referrals, number of appropriate referrals, number maintained in the community, number requiring hospitalization, number enrolled in educational courses/school and number employed.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 11

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide mental health services through Juvenile Outreach Programs (JOP) necessary for the successful transition of youth placed in juvenile detention centers back to their homes and communities

Strategies to attain the goal:

Continue funding mental health center staff provided through the CMHCs to make mental health services available to youth in juvenile detention centers in an effort to prevent reentries

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth served in detention centers

Baseline Measurement: In FY 20, 2,111 youth were served in the juvenile detention centers.

First-year target/outcome measurement: 2,115

Second-year target/outcome measurement: 2,118

Data Source:

Data is submitted monthly by the 14 JOP Programs operated through CMHCs receiving Juvenile Outreach Program (JOP) grant funding.

Description of Data:

DMH supports 14 Juvenile Outreach Programs to 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 includes number of youth served in the detention center, number exiting the detention center, number continuing mental health treatment after release from detention center, and number of reentries.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 12

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

Strategies to attain the goal:

Expand employment options for adults with SMI to achieve gainful employment; Collaborate with MDRS to increase referrals made by that agency to increase the number of people with SMI who are gainfully employed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of people with SMI who are gainfully employed; Number of referrals made to MDRS

Baseline Measurement: In FY 20, 202 referrals made to MDRS; There were 280 people with SMI who were employed in FY 20

First-year target/outcome measurement: 207 referrals to MDRS; 283 employed

Second-year target/outcome measurement: 210 referrals to MDRS; 285 employed

Data Source:

Data is submitted quarterly by the Supported Employment Programs operated by the CMHCS. Data includes number of referrals made by MDRS and number if individuals employed.

Description of Data:

Supported Employment is provided in Regions 2,3,4,7,8,9,10,11,12,14,and 15. There were 7,659 business contacts by Supported Employment Specialists in FY20. 280 individuals were employed, and of those, 202 people gained employment through the Supported Employment expansion program in partnership with MDRS or participated in the IPS Supported Employment program through Regions 2, 7, 10, and 12,

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 13

Priority Area: Recovery Supports

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Strengthen family education and family supports in the state of Mississippi

Strategies to attain the goal:

Provide a variety of training and workshops targeting people and parent/caregivers/family members of children and youth with mental health challenges throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of trainings and workshops provided through NAMI

Baseline Measurement: In FY 20, NAMI-MS provided 21 trainings and workshops to individuals with SMI and family members of individuals with SMI and children and youth with SED i

First-year target/outcome measurement: 24 trainings and workshops provided

Second-year target/outcome measurement: 26 trainings and workshops provided

Data Source:

The number of trainings and workshops provided by NAMI-MS to individuals with SMI, family members, and to parents/caregivers/guardians of children and youth with SED is submitted quarterly by NAMI to DMH.

Description of Data:

NAMI-MS submits data quarterly to DMH regarding the number of trainings and workshops provided by NAMI-MS to individuals with SMI, family members, and to parents/caregivers/guardians of children and youth with SED. DMH funds NAMI to provide recovery support services to individuals with SMI and family members of children and youth with SED by offering trainings and workshops on issues surrounding mental health challenges. Sign-in sheets and training logs are complied and data is submitted to DMH.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect 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 people receiving mental health services

Strategies to attain the goal:

DMH will offer technical assistance to providers after POM reports are released to the mental health service providers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of visits to conduct POM interviews at CMHCs

Baseline Measurement: In FY 20, 6 out of 8 POM interview visits were able to be conducted due to the safety guidelines that were mandated by the CDC and the Mississippi Department or Health during the COVID-19 pandemic.

First-year target/outcome measurement: 6 POM interview visits

Second-year target/outcome measurement: 6 POM interview visits

Data Source:

The number of Personal Outcome Measure (POM) visits to the CMHCs will be tracked and submitted to DMH quarterly by _____.

Description of Data:

The number of POM interview visits completed during each certification visit to the CMHCs will be tracked and submitted quarterly to DMH . 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 providers and technical assistance is offered based on the results of the reports.

Data issues/caveats that affect outcome measures:

There are no issues/caveats that may affect outcome measures.

Priority #: 15

Priority Area: Community Integration

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Enhance the transition process of people with serious mental illness to a less restrictive environment

Strategies to attain the goal:

Strengthen the utilization of Wellness Recovery Action Plans at the behavioral health programs to help people identify and understand their personal wellness resources

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Wellness Action Recovery Plans begun prior to discharge form behavioral health programs and CSUs

Baseline Measurement: In FY 20, there were 734 WRAPs completed prior to discharge from the behavioral health programs.

First-year target/outcome measurement: 738

Second-year target/outcome measurement: 740

Data Source:

The number of WRAPs begun prior to discharge will be submitted by the behavioral health programs and the CSUs to DMH on a quarterly basis.

Description of Data:

The number of WRAPs begun prior to discharge will be submitted by the behavioral health programs and the CSUs to DMH on a quarterly basis. Wellness Recovery Action Plans help people with SMI identify and understanding their personal wellness resources and help them develop a personalized plan to use these resources on a daily basis to manage their mental illness. In FY 20, NMSH completed 358, SMSH completed 325, and EMSH completed 51 due to a delay in receiving the WRAP booklets.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 16

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide trainings in evidence-based and best practices to a variety of stakeholders

Strategies to attain the goal:

Partner with stakeholders to expand Crisis Intervention Team Training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of officers trained in CIT

Baseline Measurement: In FY 20, there were 143 officers trained in CIT.

First-year target/outcome measurement: 145

Second-year target/outcome measurement: 147

Data Source:

At the conclusion of each CIT Training, a list of graduates is submitted to DMH by the counties providing CIT.

Description of Data:

he Division of Adult Services within the Bureau of Behavioral Health Services collects the data from graduation lists submitted by the counties providing CIT. The lists are submitted following each graduation (Desoto County, Jones County, Lauderdale County, Forrest County, Lamar County, Pike County, and Harrison County). he Division of Adult Services within the Bureau of Behavioral Health Services collects the data from graduation lists submitted by the counties providing CIT. In FY 20, there were 143 officers trained in CIT, despite the impact of COVID-19 and restricted gatherings.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 17

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase access to mental health services for youth with juvenile justice involvement

Strategies to attain the goal:

Staff from the local CMHC will attend youth court weekly meet the needs of youth referred and their families. Services include intake assessments and referrals to an array of mental health services including individual, family and group therapies, Peer Support Services, Mobile Crisis Response, Wraparound Facilitation, Community Support Services, Youth Move chapter, Family Support Council, and MAP Team.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth served through the Youth Mental Health Court program

Baseline Measurement: Pilot program; no baseline data

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 30

Data Source:

Data will be submitted monthly to DMH from a local CMHC regarding number of youth served in the program .

Description of Data:

Data submitted monthly will include number of youth referred to the program, number of intake assessments completed, number receiving mental health services, number released from juvenile justice, and number released that reentered the juvenile justice system.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

Priority #: 18

Priority Area: Crisis Services

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Begin planning for the implementation of the 988 to provide crisis response, intervene in emergencies, make referrals, and ensure callers receive appropriate and timely assistance.

Strategies to attain the goal:

A planning coalition has been formed and a consultant selected to assist in developing the 988 implementation plan. Although the strategic plan for 988 implementation has not been developed, DMH foresees a continued partnership with the CONTACT lifeline centers to answer all 988 calls. The Department of Mental Health will oversee the day-to-day operations of answering the crisis/help line for all Community Mental Health Centers as outlined in our proposal. All three entities will share data and work closely to provide crisis response, intervene in emergencies, make referrals, and ensure callers receive appropriate and timely assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Begin planning for implementation of 9-8-8 number

Baseline Measurement: New goal; baseline data will be gathered

First-year target/outcome measurement: Collaborate with the planning coalition and consultant to develop a plan for 988 implementation

Second-year target/outcome measurement: Begin implementation of the 9-8-8 number

Data Source:

Information regarding achievement of grant deliverables will be submitted by the planning coalition/consultant to DMH on a quarterly basis.

Description of Data:

DMH is currently partnering with the CONTACT lifeline centers to answer all 988 calls. The Department of Mental Health will oversee the day-to-day operations of answering the crisis/help line for all Community Mental Health Centers as outlined in our proposal. All three entities will share data and work closely to provide crisis response, intervene in emergencies, make referrals, and ensure callers receive appropriate and timely assistance. Information/data will be submitted by the consultant and/or planning coalition for the grant funding the implementation of the 9-8-8 number.

Data issues/caveats that affect outcome measures:

Other than issues surrounding the COVID-19 pandemic, there are no issues/caveats currently that may affect outcome measures.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[c]		$460,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$1,600,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$755,658.00		$1,305,228.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$20,000,000.00	$8,000,000.00	$141,144,758.00	$0.00	$40,000,000.00	$0.00		$0.00
7. Other 24-Hour Care		$0.00	$16,000,000.00	$0.00	$56,512,978.00	$0.00	$6,000,000.00	$0.00		$0.00
8. Ambulatory/Community Non-24 Hour Care		$9,787,712.00	$0.00	$6,500,000.00	$54,000,000.00	$0.00	$0.00	$5,685,429.00		$9,820,286.00
9. Administration (excluding program/provider level)[e] MHBG and SABG must be reported separately		$592,384.00	$240,000,000.00	$250,000.00	$3,500,000.00	$0.00	$5,000,000.00	$359,837.00		$621,537.00
10. Crisis Services (5 percent set-aside)[f]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$755,658.00		$1,305,228.00
11. Total	**$0.00**	**$12,440,096.00**	**$276,000,000.00**	**$14,750,000.00**	**$255,157,736.00**	**$0.00**	**$51,000,000.00**	**$7,556,582.00**	**$0.00**	**$13,052,279.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[c] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[f] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment			$500,000.00			$500,000.00
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement	$50,000.00	$0.00		$50,000.00	$0.00	
6. Research and Evaluation						
7. Training and Education	$180,000.00	$0.00		$180,000.00	$0.00	
8. Total	**$230,000.00**	**$0.00**	**$500,000.00**	**$230,000.00**	**$0.00**	**$500,000.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] 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.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

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[41] 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 promotion and welfare of individuals.

January 2019 DMH was awarded the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant Project from the Department of Health and Human Services- Substance Abuse and Mental Health Services Administration to promote collaborative partnerships with local primary healthcare organizations and mental health clinics. The goal of the project is to fully integrate and collaborate mental health and primary healthcare in two of Mississippi's most prominent cities, the capitol city of Jackson (Hinds County) and the Hub City of Hattiesburg (Forrest County). This project directly aligns with the inclusion and integration of clinical practices between primary and behavioral healthcare 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. Evidenced based practices will be utilized to achieve goals to: (a) increase holistic care capacity, (b)promote coordinated care, (c) identify behavioral and physical health concerns early, (d) facilitate communication and collaboration between health care providers, and (d) improve patient education, satisfaction and outcomes. Additionally, DMH ensures full integration of services through collaboration with fully staffed partners and multidisciplinary teams in the primary healthcare settings and the local mental health centers to provide cost effective services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and 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 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. DMH has facilitated 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 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 Division 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 Division of Alcohol and Drug Services works collaboratively with the MS Band of Choctaw Indians and continue to fund prevention services with Choctaw Behavioral Health. The DMH Division 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 Behavioral Health 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 Behavioral Health 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 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/ 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. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

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

The Mississippi Department of Mental Health

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

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ◉ No

iii) hypertension ○ Yes ◉ No

iv) high cholesterol ○ Yes ◉ No

v) 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?

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 is used to document pertinent information that will be 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

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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**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)[45].

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."[46]

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[47]. 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[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 subpopulations 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.

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? (•) Yes ( ) No

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

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

All DMH certified providers are required to develop and implement policies and procedures that address Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Hunan Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. 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. Unless federally mandated, changes to the data collection system are not possible. 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 CLAS Standards trainings are conducted upon request and the trainings have been conducted at statewide conferences. 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.

Please indicate areas of technical assistance needed related to this section

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3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA 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)**[55] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.

[49] 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

[50] 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.

[51] 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.

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

None

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

None

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Footnotes:

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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 four programs operated by Region 6, Region 8, Region 9, and Region 15 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 five CSC teams. Two-day intensive trainings have been provided to the NAVIGATE CSC Teams 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 ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

DMH funds, promotes and supports the five NAVIGATE programs described above. 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 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 2022 and FFY 2023 for your state's ESMI programs including psychosis?

Planned activities include providing education and information on the NAVIGATE Program at community events and local referral agencies in the areas served by the four (4) programs. DMH plans to utilize supplemental set aside funding to implement two new NAVIGATE programs in our state. RFPs have been disseminated to the CMHCs currently not operating NAVIGATE programs. Prior to implementation of those two programs, DMH plans to facilitate an on-site training, if possible, for new CSC team members as well as continue monthly technical assistance calls for operating programs with the NAVIGATE consultants.

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 Regions 6, 8, 9 and 15. 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.

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

None

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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 team 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, education, 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 making great progress in transforming Mississippi's public mental health system into one that is person-centered and recovery-oriented. The Initial Assessment and Individual Service Plans 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. In turn, providers are asked how they are supporting the individuals in achieving their stated dreams and goals. For each individual receiving services, the 25 Quality of Life Measures are examined to determine the individual's satisfaction with their own quality of life.

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 twelve (12) providers in the state to provide Wraparound Facilitation. Mississippi has nationally certified Wraparound Coaches that provide training and support through the Mississippi Wraparound Institute at the University of Southern Mississippi. In FY 2021, 2,160 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.

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

Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities 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 operates on a four 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 may conduct follow up visits to ensure that corrective action is taken and remains ongoing. The DMH reviews deficiencies with the goal of identifying patterns and making changes to policy as needed

Please indicate areas of technical assistance needed related to this section

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7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

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

   There have been no consultation sessions involving DMH and the MS Band of Choctaws. Please see the response to Question 3. to discover collaboration efforts between the Mississippi Department of Mental Health and the Mississippi Band of Choctaw Indians.

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

   There have been no consultation sessions involving DMH and the MS Band of Choctaws.

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

   The DMH Bureau of Behavioral Health Services works collaboratively with the MS Band of Choctaw Indians and continues to certify and fund substance us 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.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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 13 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 , and PACT Teams. In addition, 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). Mississippi has 16 Intensive Outreach and Recovery Teams (ICORT) serving 47 counties providing mental health services to individuals with serious mental illness living remote areas and lack access to mental health services.

2. Does your state coordinate 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The CHOICE program is currently available in all CMHC regions. 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,

PACT (Programs of Assertive Community Treatment) Teams include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). 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. Mississippi currently has ten (10) PACT Teams.

Intensive Community Outreach Recovery Teams (ICORT) is a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. An iCORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An iCORT is able to target more rural areas where there may be

staffing issues and clients are spread out over the geographical area. Services are provided 24-hours per day, 7-days a week just like PACT. DMH received $1 million for community-expansion in our appropriations bill for FY20 with which we add additional iCORTs. ICORTS allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service. Mississippi now has 16 ICORT teams.

Regions 6, 8, 9 and 15 operate NAVIGATE programs for youth and young adult experiencing First Episode Psychosis. NAVIGATE teams are Coordinated Specialty Care (CSC) teams of mental health professionals that 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.

Wraparound Facilitation is an approach to care planning that builds on the collective action of a committed group of family, friends,
community, professionals, and cross-system supports resources and talents from these various sources result in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies .Currently, twelve mental health providers are certified by DMH to provide Wraparound Facilitation to over 2,100 children/youth annually.

DMH supports 14 Juvenile Outreach Programs to 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.

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. On the local level, the DMH provides flexible funding to 56 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.

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.

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.

Mississippi currently has ten (10) Programs of Assertive Community Treatment Teams (PACT) that provide intensive services to adults frequently admitted to inpatient stays. These teams provide services in the community to prevent the recurrence of hospital 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. Peer Bridgers are now at all CSUs working in conjunction with Peer Bridgers at Behavioral Health Programs local CMHCs to develop WRAP plans to help people with serious mental illness manage their mental health challenges successfully.

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 20, 55 MAP teams served 786 children and youth.

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 M/SUD 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		
2.Children with SED		

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. 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.

Mississippi does not calculate incidence rates. Annually, surveys are sent to all DMH certified community mental health service providers. Included in this data is number of individuals served, among other data, which assists DMH in planning. Additionally, Mississippi obtains data through the Strategic Plan process for which data is submitted quarterly and yields boht a mid-year-and end year progress report. DMH has utilized a goal-based strategic plan to transform the public mental health system in Mississippi. The FY 21-23 DMH Strategic Plan includes three goals: To increase access to community-based care and supports through a network of service providers that are committed to a person-centered and recovery-oriented system of care; To increase access to community-based care and supports for people with intellectual and/or developmental disabilities through a network of service providers that are committed to a person-centered system of care; and To ensure people receive quality services in safe settings and utilize information/data management to enhance decision making and service delivery. The Strategic Plan is revised annually and developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan is to create a living, breathing document. The Plan was and continues to be developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. 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 preventiion 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

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

a. Describe your state's targeted services to rural population.

Programs of Assertive Community Treatment (PACT) are available 24/7 and do the majority of work with individuals at home, at work or in the community through intensive and diligent outreach strategies. Individuals who meet criteria in rural areas living with severe and persistent mental illness who are not able to benefit from traditional outpatient mental health services can be served through PACT.. Mississippi currently has 10 PACT teams operated by the following Community Mental Health Centers: Warren-Yazoo Behavioral Health, Life Help, Pine Belt Mental Healthcare Resources (operates two in Hattiesburg and Gulf Coast), Hinds Behavioral Health, Weems Community Mental Health Center, Life Core Health Group, Region 8 Mental Health Center, and Timber Hills Mental Health Services (operates two in Desoto and Corinth).

ICORT provides a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. The objective is to keep people in the community and avoid placement in state-operated behavioral health programs. An iCORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An iCORT is able to target more rural areas where there may be staffing issues and clients are spread out over the geographical area. Services are provided 24-hours per day, 7-days a week just like PACT. DMH received $1 million for community-expansion in our appropriations bill for FY20 with to provide for additional ICORTs. This will allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service. Mississippi now has 16 ICORTs. Intensive Community Support Specialists services are also offered at in each CMHC region to provide needed supports and services to individuals with serious mental illness living in rural areas of state where accessing mental health services may be difficult.

Each of the 13 Community Mental Health Centers (CMHCs) developed MCeRTs to 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 including rural areas. The goal is to respond in a timely manner to where the individual is experiencing the crisis or meet the individual at a designated location such as the local hospital. A MCeRT is staffed with a Master's level Mental Health Therapist, Community Support Specialist and Peer Support Specialist.

b. Describe your state's targeted services to the homeless population.

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.

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

c. Describe your state's targeted services to the older adult population.

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 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. 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.

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.

For the provision of mental health services for adults, financial resources include general/healthcare funds appropriated by the Mississippi State Legislature, Projects for Assistance in Transition from Homelessness (PATH) which is a federal grant program administered by the Center for Mental Health Services, and the CMHS Federal Block Grant for Community Mental Health Services mandated by the U.S. Congress. For the provision of mental health services for children and youth, financial resources include general/healthcare funding appropriated by the Mississippi State Legislature, the CMHS Federal Block Grant for Community Mental Health Services mandated by the U.S. Congress, and Project XPand federal grant funding.

The Department of Mental Health provides web-based training through Relias Learning for registered 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, Adult and Youth 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.

Training and technical assistance on mental health related topics, the DMH Record Guide, the DMH Operational standards, and service/program implementation is offered to all DMH certified providers upon request. In addition, 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.

Regarding the FFY 2021 Federal Block Grant for Community Mental Health Services, Mississippi plans to expend the funding in the following ways:
Administration Amount
Set Aside
Amount to be awarded Children's portion
Adult portion

Footnotes:

Environmental Factors and Plan

11. 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 2020-FFY 2021? ○ Yes ○ No

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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[58] paper.

57 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.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD 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) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). 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 partnered with several state and local agencies to host the annual Mississippi Trauma Informed Care Conference. 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. The 8th Annual Trauma Informed Conference will be held September 22-24, 2021, in Jackson, Mississippi.

DMH is working to provide GAINS Trauma Training for law enforcement officers throughout the state . Current plans are to offer four (4) trainings to capture all areas of the state. Initially, these trainings were planned to be in-person trainings, but due to COVID, they will be held virtually or possibly postponed until Spring 2022 to consider in-person options.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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?

The Mississippi Department of Mental Health and Region 12 CMHC have initiated a pilot project that involves Forensic Peer Support Specialists providing supports and services in jails in Jones, Forrest, and Harrison Counties. These Peer Support Specialists will serve as Peer Bridgers for people with SMI being released from jail.

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) provides 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 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. DMH and DPS recognize officers who have completed CIT training by awarding them a certificate from the DMH and DPS signed by the Executive Director of the Department of Mental Health the the Commissioner of the Department of Public Safety. CIT trained officers also receive 40 hours of CEs from DPS. CIT programs are located in Lauderdale, Pike, Jones, Forrest, Lamar and Harrison Counties. With funding from

SAMHSA, Region 12 also helped initiate CITs in two additional counties, Harrison and Pike. With the support of Region IV Mental Health, CIT programs are also in DeSoto County, with the Sheriff's Dept., Southaven PD, Horn Lake PD, Hernando PD, Olive Branch PD, Walls PD, and Baptist Memorial Hospital.

What began as an effort to develop a collaborative partnership for Juvenile Outreach Programs (JOP) in 2010 has turned into a sustained program that served 1,644 youth in FY21. DMH supports 14 JOP operated by Community Mental Health Centers throughout the state, all of which provide linkage and access to mental health services to youth who are involved in the juvenile justice system. The programs provide assessments, community support, wraparound facilitation, and a number of other services to youth with serious emotional disorders and/or mental illnesses who are in detention centers or the juvenile justice system. The goal for the youth is to improve their behavioral and emotional symptoms, and also to prevent future contacts between them and the youth courts. DMH has initiated a pilot project with Region 12 CMHC to begin a Youth Mental Health Court in Forrest and Lamar Counties. The youth referred to this program by youth court judges will receive an array of mental health services and community support services to deter future involvement with the juvenile justice system. 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. A Division of Children and Youth Services staff member also participates on the State Advisory Group for Mississippi under the Juvenile Justice and Delinquency Prevention Act.

DMH is working to provide GAINS Trauma Training for law enforcement officers throughout the state . Current plans are to offer four (4) trainings to capture all areas of the state. Initially, these trainings were planned to be in-person trainings, but due to COVID, they will be held virtually or possibly postponed until Spring 2022 to consider in-person options.

The Mississippi Legislature appropriated $600,000 for a proposal with the MS Department of Corrections focused on reducing recidivism of recently released individuals who have mental health diagnoses. A MS DOC RFP was developed and sent to three local CMHCs based on the counites that had the highest numbers of recently released individuals. This project focuses on a referral process with MS DOC to connect recently released individuals to their respective CMHC to provide mental health services and follow them while in treatment. to reduce reentries into the criminal justice system.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] 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 M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"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 M/SUD 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.

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

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

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

In 2014, each of the 14 Community Mental Health Centers (CMHCs) developed Mobile Crisis Response Teams (MCeRT) to provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the adult, child or youth is experiencing the crisis. MCeRTs work hand-in-hand with local law enforcement, Chancery Judges and Clerks, and the Crisis Stabilization Units to promote a seamless process. The Teams ensure an individual has a follow-up appointment with his or her preferred provider and monitor the individual until the appointment takes place. Without mobile crisis intervention, an adult, child or youth experiencing a crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital, or inpatient treatment program. The goal is to respond in a timely manner to where the individual is experiencing the crisis or meet the individual at a designated location such as the local hospital. A MCeRT is staffed with a master's level Mental Health Therapist, Community Support Specialist and Peer Support Specialist. In Fiscal Year 2020, there were a total of 36,921 contacts; a total of 20,322 face-to-face responses; and 2,590 responses handled in conjunction with law enforcement.

Over the last six years, MDMH has been strategically expanding community-based mental health services in Mississippi. These efforts have included the development of MCeRTs statewide, expansion of crisis stabilization unit (CSU) beds, availability of intensive community support services in all 82 counties, and a comprehensive effort to transform the system to a recovery-oriented system of care. In Fiscal Year 2019, MDMH shifted $13.3 million from institutional budgets to the Service Budget to reduce the reliance on institutional care. Of that, $8 million was for the expansion of crisis services, including additional crisis stabilization beds in the community, court liaisons, crisis counselors, and an additional Programs of Assertive Community Treatment (PACT) teams. With the funding, 44 additional CSU beds were opened across the state for a total of 172 beds. In Fiscal Years 2020 and 2021, DMH provided funding for additional Intensive Community Outreach and Recovery Teams (ICORT) for areas that did not have a PACT team for a total of 16 ICORTs in the state. These teams target more rural areas where there may be staffing issues or clients are spread out over a large geographical area and provide recovery oriented, oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness.

While mobile crisis services are operational statewide, there are still areas of improvement needed. MDMH proposes to set aside $328,764 of block grant funds to expand and support our statewide toll-free phone number so that all crisis calls will be received in one location; documented; and triaged to the appropriate MCeRT. Currently, adults, children, youth and their families in crisis can access assistance by contacting one of 15 different phone numbers. This is due to each of the CMHCs operating individual, toll-free numbers for each of their catchment areas. MDMH believes that one toll-free crisis line would provide easier access to crisis services for Mississippians in need. Additionally, it would allow our state to streamline crisis data by entering the data into one central database. This will help MDHM make informed decisions about crisis services and ensure crisis response and follow up is consistent statewide. MDMH currently operates an information/referral, crisis "helpline". There were 6,174 total calls to the MDMH Helpline in Fiscal Year 2020, which is an increase from 5,767 calls received in Fiscal Year 2019. MDMH plans to establish the current helpline number as a one-stop crisis line number to serve adults, children, and youth across the entire state. Funds will support salaries for 12 additional staff to operate the crisis call line 24 hours a day, 7 days a week, 365 days a year.

In characterizing Mississippi's current crisis system, the following data was used:
• Someone to talk to – There are currently 18 call centers in the state; two are within the Suicide Lifeline Network; one is the DMH helpline; and 15 crisis lines are maintained by 13 different CMHCs. MDMH is proposing to consolidate the 15 phone numbers into one main crisis line. Two of the crisis call centers have follow-up protocols. There were over 6000 calls received statewide last fiscal year.
• Someone to respond - Mississippi has 13 crisis mobile responder teams that are independent of first responder structures. All 13 crisis mobile responder teams employ peers. In Fiscal Year 2020, there were a total of 36,921 contacts; a total of 20,322 face-to-face responses; and 2,590 responses handled in conjunction with law enforcement.
• Places to Go – There are currently 13 crisis stabilization units in the state.

Current Activities
• In 2014, each of the state's CMHCs developed a Mobile Crisis Response Team. In FY15, the first full year these teams were operational, they received 19,660 total calls and had 9,701 face-to-face contacts. Last year, FY20, the teams received 36,921 calls and had 20,322 face-to-face visits. These services are provided in all 82 counties. These Teams work hand-in-hand with local law enforcement, Chancery Judges and Clerks, and the Crisis Stabilization Units to promote a seamless process. The Teams ensure the adult, child or youth has a follow-up appointment with his or her preferred provider and monitor the individual until the appointment takes place. Without mobile crisis intervention, an individual experiencing a crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital, or inpatient treatment program. The goal is to respond in a timely manner to where the adult, child or youth is experiencing the crisis or meet the individual at a designated location such as the local hospital.

• In 2011, Mississippi had two PACT teams. Mississippi now has 10 PACT teams that provide services in the community for individuals who have severe and persistent mental illness and have benefited from traditional outpatient services. These teams

served 173 people in FY15, but they served 535 in FY20. Mississippi Youth Programs Around the Clock (MYPAC) is a home and community-based Medicaid program for children and youth with Serious Emotional Disturbance (SED), that follows the high-fidelity Wraparound process. MYPAC provides an array of services, including crisis services, as an alternative to traditional Psychiatric Residential Treatment Facilities (PRTF). Wraparound Facilitation, a DMH certified component of MYPAC and an all-inclusive planning process that is youth-guided and family-driven, brings community services and natural supports together from various parts of the youth and family's life. In 2020, 2,080 children and youth with SED in Mississippi were served by Wraparound Facilitation.

• DMH has also funded the development of Intensive Community Outreach and Recovery Teams (ICORTs), which are similar to PACT in that they provide intensive, mobile services to people with severe mental illness, but an ICORT has fewer staffing requirements that allow them to target more rural areas. DMH piloted this program in FY19, funded five new ICORTs in FY20. With PACT and ICORT combined, there was a 30 percent increase in the number of individuals receiving these intensive community services in FY20 compared to the prior year. Beginning September 1, 2020, ICORT is now a service available to children and youth with SED and their families.

• When DMH shifted $13.3 million from its institutional budgets in FY19, allowed for creation of additional Crisis Stabilization Units (CSU) in the state. Previously, there were eight, 16-bed units in the state. This shift allowed additional crisis stabilization beds to open in CMHC regions that did not have CSUs. There are now 172 CSU beds in the state, an increase from 128 beds prior. A 12-bed Children's CSU serving ages 6-17 is operated by a CMHC and located in the central portion of the state. A second 12-bed CSU for children and youth is planned to open this spring serving primarily children and youth in the custody of Child Protection Services and children and youth who are victims of trafficking.

• The additional funding for community services and the funding shifted from DMH's institutional programs has allowed for this expansion, and it is ongoing this year as well. In FY21 alone, the state's current fiscal year, DMH has provided funding for nine additional ICORTs and additional Intensive Community Support Specialists (ICSS). All of the state's 82 counties now have PACT, ICORT, or ICSS services.

Other initiatives have included:
• The Peer Bridger program, which connects individuals served at state hospitals with Certified Peer Support Specialists to aid in the transition process as someone is discharged from a state hospital. This program began at North Mississippi State Hospital, became operational at South Mississippi State Hospital last year, and will be expanding to the state's two remaining state hospitals this fiscal year.
• CPSSs have been included on Mobile Crisis Response Teams, PACT Teams, Supported Employment pilot sites, and other areas throughout the public mental health system. These individuals use their lived experiences in combination with skills training to support peers and/ or family members with similar experiences. CPSSs are employed at all DMH operated behavioral health programs for adults. Mississippi's CPSS training is an intensive, 34-hour course followed by a written exam. CPSSs are individuals who self-identify as a family member or an individual who received or is currently receiving mental health services. Upon completion of the training, successfully passing the CPSS examinations, and obtaining employment by a DMH certified provider, participants become CPSSs. The training and certification process prepares CPSSs to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve. There are four designations of Certified Peer Support Specialists serving Mississippians. These designations include CPSS – Adult, Parent/Caregiver CPSS, CPSS Young Adult, and CPSS – Recovery.
• DMH is working to strengthen the utilization of Wellness Recovery Action Plans at the behavioral health programs to help patients through the process of identifying and understanding their personal wellness resources and help them develop a personalized plan to use these resources on a daily basis to manage their mental illness. There were 308 WRAP conducted at state hospitals prior to discharge in FY20 and an additional 473 Illness Management and Recovery groups conducted.

Implementation of 988
DMH recognizes the importance for Mississippi (MS) callers to the National Suicide Prevention Lifeline (NSPL) to be served by crisis counselors within the state. DMH has focused on expanding suicide prevention efforts statewide and in turn, the call volume to the NSPL has steadily increased. As a result, DMH contracted with CONTACT the Crisis Line (CONTACT) to answer lifeline calls for MS. MS has increased our answer rate percentage from 46% to 90% over the past few years. The state also has CONTACT Helpline in Columbus which answers lifeline calls for 6 counties in the Northeast part of MS which will be included in the planning and implementation of the 9-8-8 grant.
The Department of Mental Health has received the planning grant from Vibrant Emotional Health and the state is in the early stages of developing a roadmap for 988 implementation. A planning coalition has been formed and a consultant selected to assist in developing the 988 implementation plan. Although the strategic plan for 988 implementation has not been developed, DMH foresees a continued partnership with the CONTACT lifeline centers to answer all 988 calls. The Department of Mental Health will oversee the day-to-day operations of answering the crisis/help line for all Community Mental Health Centers as outlined in our proposal. All three entities will share data and work closely to provide crisis response, intervene in emergencies, make referrals, and ensure callers receive appropriate and timely assistance.

Available Children's Services
Many services for adults are also available for children and youth. Mobile Crisis Response Services include children and youth statewide. There is also a children's Crisis Stabilization Unit operated by Hinds Behavioral Health Community Mental Health

Center. A second 12-bed CSU for children and youth is planned to open this spring. ICORT is now a service available to children and youth with SED and their families. Wraparound Facilitation is a youth-guided and family-driven service that brings community services and natural supports together from various parts of the youth and family's life. Fifty-five Multidisciplinary Assessment and Planning (MAP) Teams provide resources and support to children and families across the state to serve children and youth in their own community and reduce the risk of inappropriate institutional placement. The 988 toll-free number previously mentioned can be accessed for children and youth in crisis as well as individual's looking for resources and help with navigating the system.

Conclusion

Utilizing crisis funds to support the staffing of a crisis line center centralized within the MDMH will ensure continuity of care through the state, as well as provide easier access to crisis services to all Mississippians in need. There will be one toll-free number for an individual and/or families to call when in need of crisis response. Data will be centralized and input into one system, which will allow the state to make informed decisions regarding crisis service needs and ensure crisis response and follow up is consistent statewide.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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 ( ) No

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 FY22 – FY23 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.

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: (1) 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; (2) Delivery of Services – Consumers and family members are employed as Certified Peer Support Specialists; and (3) 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.

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 Mental Health Planning Councils and various 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.

The DMH's Peer Support Specialist Program began in 2012. As of June 2021, over 370 family and peers have completed the CPSS training with over 75% of those trained becoming certified. In FY 2020-2021, 138 peers and family members were trained in the Certified Peer Support Specialist Training and 287 Certified Peer Support Specialists (CPSS) were employed within 43 DMH Certified Providers throughout the state mental health system. Certification is required for Peer Support Specialists in Mississippi, which leads directly to employment opportunities. Three designations exist for CPSSs in Mississippi: Certified Peer Support Specialist – Adult (CPSS-A), Certified Peer Support Specialist – Parent/Caregiver (CPSS-P), and Certified Peer Support Specialist – Young Adult (CPSS-Y). 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 continue to support the operation of the Association of Mississippi Peer Support Specialists (AMPSS).

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, CPSS supervisors and other CMHC staff members and 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.

Additionally, The Mississippi Department of Mental Health Peer Bridger Model has been implemented to award individuals with psychiatric disability and/or substance use disorder the best chance of sustained recovery and reduce the probability of hospitalization. The Peer Bridger Model is an evidence-based intervention that has been shown to reduce hospitalization length of stay and reduce re-hospitalization rate after discharge from psychiatric hospitals. This model accomplishes these goals using Peer Bridgers-persons who have been successfully managing their own recovery from a psychiatric disability and/or substance use disorder. The Peer Bridger Model describes the process whereby individuals who are involuntarily committed to Behavioral Health Program are assisted in their transition back to their communities for continued care.

The Mississippi Department of Mental Health Peer Bridger Model is designed to MATCH a Peer Bridger who is successfully managing his or her own recovery and has completed the required Peer Bridger Project Training offered by Mississippi Department of Mental Health, with people who have been involuntarily committed to a Behavioral Health Program. Individuals involuntarily committed and discharged from the Behavioral Health Program will be offered a Peer Bridger. Priority is given to individuals who have had a lengthy hospitalization or a history of frequent, multiple hospitalizations. Participation in this project is completely voluntary. The primary function of this project is the development of a supportive and trusting relationship between the person and the Peer Bridger. Peer mentoring, support, advocacy, and skill building will be provided for these peers through regular individual contact over time. The goals are (1) to ease the transition of individuals being discharged from hospital settings back into community life; (2) to significantly decrease the need for readmission to the hospital, and (3) to significantly decrease the need for hospitalization by engaging people prior to entry into the inpatient facilities. As of July 2021, Peer Bridger Programs have been implemented in two state hospitals (i.e., North MS State Hospital, and and South MS State Hospital) and all 13 community mental health centers (CMHCs) through the state. The program will be added to the remaining two state hospitals in FY 22.

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

The Mississippi Department of Mental Health (DMH) Strategic Plan is a living document depicting the direction the Department is taking to meet the goals and changing demands of mental health care in Mississippi. Through the outcomes in the DMH Strategic Plan, our goal is to inspire hope, assist people on the road to recovery, and improve resiliency, to help Mississippians succeed. Goal 1 sets forth DMH's vision of people receiving services having a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. This goal highlights the focus on a community-based service system and is woven throughout the entire Strategic Plan; however, Goal 1 emphasizes the development of new and expanded services in the priority areas of crisis services, housing, intensive community support services, peer support, supported employment, long-term community supports and other specialized services to help people transition from inpatient care to the community and help people remain in the community. The activities highlighted below are addressing community integration as required by the Olmstead Decision of 1999 and are included in DMH's strategic plan and annual reports.

The expansion of community services in the state includes a range of services, from crisis response services to ongoing programs designed to provide an intensive level of service to prevent hospitalization.

Crisis Stabilization Units In FY19, DMH shifted funds from its inpatient programs to provide additional funding for crisis stabilization beds in the state. There were previously eight, 16-bed CSUs around the state. There are now 13 with 176 beds. Region 11 is currently working on a CSU and DMH is making available funding in FY22 for a CSU in DeSoto County. DMH will also be adding funds to the current CSUs for enhancement such as security to make more difficult patients. The beds offer time-limited residential treatment services to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient treatment. In FY20, CSUs served 3,525 individuals. 91.5% of those individuals were diverted from inpatient services at a state hospital.

Housing: 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. 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 13 Community Mental Health Centers (CMHCs). 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. 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.

Mobile Crisis All 13 CMHCs have developed Mobile Crisis Response Teams (MCeRTs) to 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. MCeRTs work hand-in-hand with local law enforcement, Chancery Judges and Clerks, and the Crisis Stabilization Units to promote a seamless process. The Teams ensure an individual has a follow-up appointment with his or her preferred provider and monitor the individual until the appointment takes place. Without mobile crisis intervention, an individual experiencing a crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital, or inpatient treatment program. The goal is to respond in a timely manner to where the individual is experiencing the crisis or meet the individual at a designated location such as the local hospital. A MCeRT is staffed with a Master's level Mental Health Therapist, Community Support Specialist and Peer Support Specialist.

Peer Support DMH partnered with Certified Peer Support Specialists (CPSSs) across the state to develop the Think Recovery campaign to help increase the knowledge of service providers and individuals on the Components of Recovery. The campaign engaged consumers in the planning, development and implementation of the campaign. The campaign highlights the importance of community integration and focuses on sharing personal stories of recovery. CPSSs have been included on Mobile Crisis Response Teams, PACT Teams, Supported Employment pilot sites, and other areas throughout the

public mental health system. A CPSS is an individual or family member of an individual who has self-identified as having received or is presently receiving behavioral health services. A CPSS has successfully completed formal training recognized by DMH and is employed by a DMH Certified Provider. These individuals use their lived experiences in combination with skills training to support peers and/ or family members with similar experiences. Mississippi began the CPSS program in 2012 and has 280 active CPSSs as of the end of FY21. CPSSs are employed at all of the DMH operated behavioral health programs for adults. The first CPSSs with a designation of a Parent/Caregiver completed their training at DMH in March 2017. The Parent/Caregiver designation is an expansion of the CPSS Program. Although Mississippi has a successful CPSS training program geared toward adults in recovery, this new designation of peers focuses on those who will be working with children with behavioral health issues. The training is a customized, two-day block within the current CPSS training program.

To further enhance the emphasis on Peer Support in our state, over the next year we will provide funding to the CMHCs to employ a CPSS at all Crisis Stabilization Units (CSUs) in the state. CSUs offer time-limited residential treatment services to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient treatment. The Substance Abuse and Mental Health Services Administration National Guidelines for Behavioral Health Crisis Care recommends having peer support integrated into crisis programs such as mobile crisis and crisis stabilization. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. We are excited to enhance the operation of the CSUs by funding additional peer support.

We will also be expanding the Peer Bridger program to all state hospitals and CMHCs over the next year. DMH currently funds a Peer Bridger Program in North Mississippi with three regional CMHCs and North Mississippi State Hospital. A second Peer Bridger Program began in late 2020 in South Mississippi with two regional CMHCs and South Mississippi State Hospital. The goal of the Peer Bridger Program is to enhance the transition process to decrease a person's need for readmissions and increase the number of people who attend follow-up appointments by offering peer support services through a Peer Bridger. This program will be expanded to Mississippi State Hospital and East Mississippi State Hospital and the remaining CMHCs.

Community Transition Homes DMH, Region 8 Community Mental Health Center, Hinds Behavioral Health Services, and The Arc of Mississippi have partnered to provide community-based living opportunities for individuals that have been receiving continued treatment services at Mississippi State Hospital. Region 8 began a Community Transition Home for four females in Simpson County in April 2018 and has added an

additional house for four more females. Region 9 began a Community Transition Home in May 2018 for four males in the Jackson area. These individuals have been unsuccessful living in the community in the past. Now, with 24/7 support and assistance, the individuals pay their own rent, purchase their own food and participate in community.

MOU with Medicaid A Memorandum of Understanding between DMH and the Division of Medicaid (DOM) is easing the transition process for people who have received services at DMH's state hospitals. Implemented on July 1, 2018, the MOU has three core components:

1) DMH social workers can now submit applications for people who are receiving services in the state hospitals. Previously, DMH staff would only assist with this process close to the patient's discharge date, since Medicaid cannot provide benefits to someone while they are in a DMH hospital. If the application is approved before discharge, those benefits will still be restricted until after discharge.
2) People who receiving Medicaid benefits prior to admission at a DMH hospital will retain their enrollment in the Medicaid program, but restrictions will apply while they are receiving inpatient services at a DMH hospital. Those restrictions will be lifted at discharge, and the patient will not have to complete the Medicaid application process again.
3) Benefits will be unrestricted if the patient, while still in the care of DMH, requires additional inpatient treatment at another medical program. This unrestricting allows Medicaid to provide reimbursement for qualifying medical needs while the patient will be returning to a DMH hospital.

PACT Teams In FY19, DMH provided funding for two additional PACT Teams - Region 8 Mental Health Center and Timber Hills Mental Health Services. Mississippi currently has 10 PACT teams operated by the following Community Mental Health Centers: Warren-Yazoo Behavioral Health, Life Help, Pine Belt Mental Healthcare Resources (operates two in Hattiesburg and Gulf Coast), Hinds Behavioral Health, Weems Community Mental Health Center, Life Core Health Group, Region 8 Mental Health Center, and Timber Hills Mental Health Services (operates two in Desoto and Corinth).

Supported Employment DMH researched best practices and chose the Supported Employment Programs of Individual Placement and Support (IPS). Supported Employment, an evidenced-based way to help people diagnosed with mental illnesses secure and keep employment, begins with the idea that every person with a serious mental illness is capable of working competitively in the community. In FY18, there were

four Supported Employment sites, Region 2, 7, 10, and 12. To help expand the programs, in the second quarter of FY19, DMH provided funding to Community Mental Health Centers to add seven more Supported Employment programs at Region 3, 4, 8, 9, 11, 14, and 15. DMH has developed a MOU with Department of Rehabilitative Services to assist with training and job placement. In FY22, DMH will be funding an additional three IPS sites. All 13 CMHCs have either a IPS site or Supported Employment Specialist in partnership with the Department of Rehabilitative Services.

Bed Tracking System A bed dashboard has been created for crisis and community beds. CSUs and CMHCs update their bed status daily when they run their daily census. In the third quarter of FY19, DMH received a grant from NASMHPD to enhance the bed registry tracking system.

Transitions DMH has established a Transition Workgroup with representatives from state hospitals, community providers, peer specialists, and Central Office to make recommendations to improve the transition process for people leaving the state hospitals. DMH is partnering with the Department of Health to increase the awareness of the connection between chronic disease and mental health. The goal is to help improve physical health and mental health outcomes for people who have a chronic disease as they transition to the community.

Crisis Intervention Teams Crisis Intervention Teams are partnerships between local law enforcement agencies and a variety of agencies, including Community Mental Health Centers, primary health providers, advocacy groups such as NAMI, and behavioral health professionals. Officers joining a team learn the skills they need to respond to people experiencing a mental health crisis and divert them to an appropriate setting for treatment, ensuring people are not arrested and taken to jail due to the symptoms of their illness. Fully-operating Crisis Intervention Teams are now in Hinds County CIT, Northeast Mississippi CIT, Pine Belt CIT, Pike County CIT, and the Northwest Mississippi CIT. Stakeholders in Harrison County and Warren County are also taking steps to establish a CIT.

Drop-In Centers DMH helps fund three centers across the state. The centers provide a wide variety of services to help homeless individuals with serious mental illness gain access to housing, treatment, and recovery support. Peers help individuals build social skills, self-confidence, self-advocacy, and support systems. The drop-in centers also provide access to basic needs such as food, showers, toiletries, clothes, laundry, telephones, and mail. Individuals may voluntarily drop-in and participate in activities or use any of the center's services. Mississippi currently has drop-in centers in Harrison, Forrest, Jackson, and Hinds counties.

Integrated Care Grant DMH received a grant for the Integration of Primary and Behavioral Healthcare in Region 12 and region 9. DMH is partnering with the CMHCs and Federally Qualified Health Clinics to co-locate services.

ICORT In FY19, DMH piloted Intensive Community Outreach and Recovery Teams (ICORT), with the Region 2 CMHC, Communicare. It is a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. The objective is to keep people in the community and avoid placement in state-operated behavioral health programs. DMH funded five new ICORT teams in FY20, for a total of six teams in Regions 1, 2, 6, 7, 11, and 14. In FY21, DMH funded additional ICORTs in Region 2, 7, 8, 9, 10, 11, and 12 in FY21. Mississippi now has 16 ICORTs. These teams are able to target more rural areas where there may be staffing issues or clients are spread out over a large geographical area. An ICORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An ICORT is staffed with registered nurse, Master's level Mental Health Therapist, a Certified Peer Support Specialist and an administrative assistant. ICORT can also utilize a part-time Community Support Specialist if needed. ICORT is a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. ICORTs are mobile and deliver services in the community to enable an individual to live in his or her own residence.

DMH has also expanded the use of Intensive Community Support Specialists. In FY20, Region 3, 6, 9, 10 received grants for two additional ICSS. Region 11 will receive a grant for four additional ICSS. Mississippi now has 35 ICSSs. Each with capacity to serve up to 20 people. ICSS is designed to be a key part of the continuum of mental health services and supports for with serious mental illness. ICSS differs from typical Community Support Services and Targeted Case Management by: 1. Engaging with community settings of people with severe functional impairments; 2. Serving consumers in the community who have traditionally been managed in psychiatric hospitals; 3. Maintaining an unusually low client to staff ratio; Providing services multiple times per week as needed; and, Providing interventions primarily in the community rather than in office settings.

All 82 counties in Mississippi have access to an intensive community support such as PACT, ICORT or ICSS to help people remain in their community and avoid unnecessary hospitalization.

Environmental Factors and Plan

18. Children and Adolescents M/SUD 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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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 M/SUD 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).

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

[64]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.

[65]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.

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

[67]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/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 M/SUD 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 M/SUD 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 awarded a Cooperative Agreement to begin October 1, 2017, which focues on youth who are involved with the child welfare and/or juvenile justice systems, referred to as “crossover youth”. The Crossover XPand SOC project, which will end September 30, 2021,expanded current and graduated System of Care (SOC) programs in two jurisdictions served by Pine Belt Mental Healthcare Resources and Weems Community Mental Health by prioritizing underserved children and youth involved in the child welfare/advocacy system and/or the juvenile justice system, referred to as "crossover youth," and those at risk for becoming crossover youth, and their families. The priority children and youth had a diagnosed serious emotional disorder (SED), co-occurring disorder (COD), or first episode of psychosis (FEP), between the ages of 3 -21, resided in Forrest, Jones, Lauderdale, or Marion Counties in Mississippi, and were involved with child protection services and/or juvenile justice, or are at risk for involvement. The DMH partnered with Regions 12 and 14 in the Spring of 2021 to apply for another SOC Expansion grant that will continue to expand System of Care principles and services across our coastal counties.

The goals of Crossover XPand SOC were: 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.

Fourteen (14) Juvenile Outreach Programs provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The programs provide 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.

A local CMCH will begin operating a Youth Mental Health Court in FY22. This collaboration between the DMH Division of Children and Youth Services, Region 12 CMHC, and the Forrest and Lamar County Youth Courts will provide an alternative to juvenile detention for youth charged with unlawful behavior. Youth ordered to the program will receive an array of mental health services to provide them the opportunity to experience success and deter any further unlawful behavior or reentry into the juvenile justice system.

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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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.

The Mississippi Department of Mental Health (DMH) established the state's first Suicide Prevention Workgroup in April 2016 to develop the state's first three-year Suicide Prevention Plan which was released in September 2016. DMH updated the plan in 2019. The three-year plan formalized suicide prevention efforts already taking place in the state and set a series of goals and objectives to accomplish over the course of the three year plan. Since its inception, DMH has released four Progress Reports documenting accomplishments made in FY 2017 - 2020. The Plans and Progress Reports can be viewed at http://www.dmh.ms.gov/resources/ under "Suicide Prevention." An FY 2021 Progress Report will be available in September 2021.

Over the last fiscal year, DMH and statewide partners have worked diligently to make progress with the objectives in the plan. DMH continues to provide evidence-based training in Mental Health First Aid and ASIST. There were 558 people trained in Mental Health First Aid (518 in Youth and 40 in Adult) and 41 people trained in Suicide Risk Assessment offered by the Southeast Mental Health Technology Transfer Center during FY20. As part of the Southeast Mental Health Technology Transfer Center Network, DMH was able to offer an interactive no-cost, technical assistance opportunity provided by Georgia Hope and targeted to master's level and licensed mental health clinicians who provide counseling and/or assessment in a variety of settings. The training highlighted the importance of suicide risk assessment and demonstrated ways clinicians can recognize, assess, and intervene when working with at-risk clients. Mental health and crisis resources that include the National Suicide Prevention Lifeline as well as DMH's Helpline have been distributed to each person who receives Shatter the Silence, Mental Health First Aid and ASIST training.

In FY20, DMH expanded the number of people trained to provide Shatter the Silence to 59 through four train the trainer sessions. From July 1, 2019 to June 30, 2020, there were 8,167 people trained in Shatter the Silence: Suicide-The Secret You Shouldn't Keep. Information in the training includes risk and protective factors, warning signs, and referral information. DMH continues our partnership with the Mississippi Department of Public Safety (DPS) to train Highway Patrol officers in Shatter the Silence. In FY20, there were 157 law enforcement officers trained. DPS also distributes lethal means educational cards that encourage responsible gun safety to reduce deaths by suicide with every gun permit issued. In FY 20, 7,797 cards were issued to gun owners. Additionally, 1,105 members of the National Guard and their families were trained in Shatter the Silence's military version through Yellow Ribbon events throughout the state.

House Bill 263 was passed in the 2017-2018 school year and requires that all school district employees receive suicide prevention training in the 2017-2018 school year, and new employees thereafter. In 2019, House Bill 1283, entitled "The Mississippi School Safety Act Of 2019" required local school districts to conduct, every two years, refresher training on mental health and suicide prevention for all school employees and personnel, including all cafeteria workers, custodians, teachers, and administrators. In November 2019, a focus group of school district staff and representatives from the Mississippi Department of Education (MDE) and DMH met to review and select trainings and provided these

recommendations to MDE. As part of the legislation, the MDE was also required to establish three pilot sites in six school districts utilizing an evidence-based curriculum to provide students in K-5 with skills to manage stress and anxiety. DMH has piloted the program in ten schools and was responsible for the selection of the content of the curriculum. A focus group was convened in the fall of 2019 to select the content. The results of the program are being measured and reported in consideration of statewide implementation.

DMH is also a recipient of SAMHSA's Garrett Lee Smith (GLS) Youth Suicide Prevention grant that The

purpose of the grant is to support the state with implementing youth suicide prevent ion and early

intervention strategies in schools, educational institutions, juvenile justice systems, substance use

programs, mental health programs, foster care systems, and other child and youth-serving organizations. DMH has partnered with Region 8 Community Mental Health Center to implement mental health and suicide risk screenings in 6 school districts over the course of the 5-year grant. Additionally, Mississippi State University and DMH have partnered to provide The Alliance Project gatekeeper and postvention trainings to the population of focus.

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

The state's second three-year suicide prevention plan is approaching its final year (FY2022) and has accomplished many of the goals set (described above) to address suicide in Mississippi. Additionally, DMH was awarded an Emergency Response to COVID-19 grant from SAMHSA in FY20. Through that initiative, the Behind the Mask awareness campaign was established to encourage Mississippians who have been affected by the COVID-19 pandemic to seek mental health and/or alcohol and drug treatment services. The grant has a specific focus on frontline workers like healthcare and first responders who may be experiencing overwhelming stress and repeated trauma during the pandemic.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

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?

Newly established partnerships include the MS Department of Employment Security Commission, State Department of Health's Injury and Violence Prevention Bureau, the Community College Board and the following Community Colleges: Pearl River Community College, East Central Community College, Meridian Community College, Itawamba Community College, Copiah Lincoln Community College, and East Mississippi Community College.

As a part of the Governor's Challenge to prevent suicide among Service Members, Veterans and their Families, DMH has partnered with Mississippi Veterans Affairs, the G.V. Sonny Montgomery Medical Center, Columbus Air Force Base, National Guard, Mississippi Hospital Association, Mississippi State University Department of Psychology, Mississippi State University Extension Service, and the Mississippi Attorney General's office as well as many community mental health centers and advocacy organizations.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC).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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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 M/SUD 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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

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

The Division of Alcohol and Drug Services 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.

In Mississippi, the Councils for Alcohol and Drug Services and Mental Health have not traditionally held joint quarterly meetings. However, since the beginning of the pandemic, the two councils are meeting in a combined, virtual format. Additionally, two representatives from the Alcohol and Drug Services Advisory Council also serve on the Mental Health Planning and Advisory Council. Although submitted separately, the Bureau of Behavioral Health Services work together in the development of the SABG and MHBG.

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

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

3. Please describe 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 2022-2023 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. Minutes from the Planning Council meetings held in FY 2021 are included in this application in the attachments.

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 2021 meeting. The public comment period began August 25, 2021, - September 14, 2021. The Council also has the opportunity for review of the FY 2022-23 State Plan Draft during that time.

Public notices of the availability of the Draft Plan for public review and comment are made available at the 13 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 is 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 is 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
Office of the Governor, Division of Medicaid
Department of Psychiatry and Human Behavior, University of MS Medical Center
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 are 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 Planning Council continues to be expanded to include representatives of all populations. Several African Americans, senior adults, a representative from the VA Medical Center, and a representative from the Mississippi Band of Choctaw Indians are members of the Council.

The MS Department of Mental Health Community Mental Health Services FY 2022-23 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 Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Mental Health and Substance Abuse Block Grant
Joint Planning & Advisory Council
Meeting Minutes
December 10, 2020

Present: Patricia Battle, Hon. Mark Chaney, Amanda Clement, David Connell, Chelsea Crittle, Kay Daneault, Andrew Day, Annette Giessner, Maxi Gordon, Joe Grist, Ronny Henderson, Jamie Himes, Joe Kinnan, Sandy Kinnan, Toniya Lay, Kennan LeSure, Harriette Mastin, Janet McCrory, Curtis Oliver, Elaine Owens, Julie Powell, Coreaner Price, Angel Quadrani, Bill Rosamond, Terry Session, Tony Sheppard, Degarrette Tureaud, Larry Waller, Natalie Webster, Tommie Whitten, Auvergne Williams, Sitaniel Wimbley, Melody Worsham

DMH Staff Present: Wendy Bailey, Felita Bell, Misty Bell, Kelly Breland, Eileen Ewing, Shane Garrard, Brent Hurley, Jake Hutchins, Tressa Knutson, LaTarsha Michael, Diana Mikula, Darlene Murphy, Chuck Oliphant, Julie Propst, Lynda Stewart, Grenaye Sullivan, Carman Weaver, Belen White, Eric Wilson

Welcome and Meeting Overview – Jake Hutchins and Shane Garrard

Mr. Hutchins called the virtual meeting to order and welcomed everyone. The A&D Council Chair comments and agenda will be first. Then the Planning & Advisory Council Chair will open with comments and their agenda.

Ms. Diana Mikula will be retiring at the end of January 2021, and Ms. Wendy Bailey will be the new DMH Executive Director.

Ms. Mikula thanked the council for their dedicated service and encouraged them to continue their great work.

Ms. Bailey is confident in the staff and state partners as we move into 2021. The council wants to see improvements in the state's system, and this is an amazing team, each with a significant role, to accomplish these improvements. Ms. Bailey hopes to move forward on this shared mission with respect and appreciation. She looks forward to working with everyone on the council.

Mr. Steven Allen planned to retire in June 2020 but stayed with the department in an effort to maintain continuity with DMH programs and providers during the pandemic. Mr. Allen is retiring at the end of December 2020.

Mr. Allen said that this is an amazing group of people and all want the best for those we serve. DMH has some amazing people in the right place at the right time at central office. This agency is in great hands and has a bright future. Ms. Mikula has done an exceptional job since being there and Ms. Bailey is going to do an excellent job going forward, as she has already.

Mental Health Council Comments

P&A Council Chair, Mr. Connell, thanked the council for going through this difficult time together. He hopes to be able to meet in person in the future.

Sandra Parks, a member of the DMH family, passed away in November. She was a long-time member of the council and was loved by all.

Approval of Minutes

It was moved by Hon. Chaney and seconded Ms. Worsham that the February 6, 2020, minutes be approved. The motion passed.

Old Business

There was no old business.

New Business

Intensive Community Services Update
Jake Hutchins – DMH, Director of Behavioral Services

With the FY21 funding, DMH was able to add 9 additional Intensive Community Outreach and Recovery Teams (ICORT), totaling 16 across the state. DMH is working with the Department of Medicaid for additional ICORT funding. Twelve Intensive Community Support Specialists were added, to make a total of 35. There was funding to enhance Mobile Crisis Response Teams (MCeRT). Some of these teams serve huge catchment areas. Funding provided for MS United to End Homelessness Open Doors, to assist individuals with CHOICE vouchers. With more intensive services across the state, DMH is also hoping to expand CHOICE vouchers. As of 2020, 258 individuals were housed on CHOICE vouchers. DMH is going to expand a module through the Web Interface Treatment System (WITS) with a crisis model in order to track every step of crisis calls. Each county now has some type of crisis coverage. With the addition of intensive services, the state has 10 PACT Teams. There was a push approximately 3 funding cycles ago to make sure there is a crisis stabilization unit in each one of the CMHC regions. Currently, there is a CSU (4/8/16 beds) in every region (13 CSU's), except for Region 15. Region 15 did not think a CSU was the wisest use of the funding and they have a MOU with Region 6 to use crisis stabilization beds as well as with River Region Health Systems. Region 15 chose to start ICORT teams. Two children's CSU's have been opened. One at HBHS and the other at Methodist Children's Home. Since beginning with 4 supported employment sites, DMH has added enough for all CMHC's to have a Supported Employment Specialist on staff. The CPSS program has been a success with 271 CPSS's employed across the state. The Peer Bridger Project was started several years ago at NMSH and 3 CMHC's in that catchment area. Individuals from New York just trained on the Peer Bridger Program. After the first of the year, plans are to include this program at MSH, EMSH and all CMHC's in those catchment areas.

A year ago, Pearl River County in Region 13 approached Pine Belt Mental Health to join them. DMH was notified a month ago by the employees of Region 13 that the remaining counties (Stone, Hancock, Harrison) will be joining Region 12 as well. As of February 1, 2021, they will become Pine Belt Mental Health Center and Region 13 will no longer exist. DMH has been working with the CMHC directors to work out budgets and logistics.

FY20 State Plan Implementation Report
Lynda Stewart – Mississippi Department of Mental Health
Division of Children and Youth Services Director

The FY20 State Plan Implementation Report goes along with the Block Grant application. The allocation for this grant is approximately $6.2 million with $622,000 set aside for NAVIGATE programs. NAVIGATE is the first episode psychosis program for individuals ages 15-30. The report was submitted on time, December 1, 2020. DMH was able to achieve a great deal with what was afforded in the Implementation Report. Very few goals and objectives were not achieved and those not achieved were extremely close. The pandemic played a huge part as a barrier in achieving those goals. In mid-January all states submitting a FY2021 Mental Health Block Grant application were required to revise two tables. Mississippi completed that based on new allotments introduced for FY20. The FY20 Implementation Report is on the DMH website under the Community Mental Health documents. For questions, please contact Lynda Stewart at lynda.stewart@dmh.ms.gov.

Proposed Mental Health 2021 Projects
Melody Worsham – Mental Health Association of South Mississippi

The Proposed Mental Health 2021 Projects recommendation was submitted and reviewed by Ms. Melody Worsham. It was suggested to change the council name to "Community Integration Advisory Council" to reflect the focus of an advisory capacity. This name is also used in other states who have similar councils. Also, the council's focus could be changed to study and discuss all matters pertaining to barriers and challenges of community integration. This would allow for open discussion and solutions to possibly offer the agencies most affected by these obstacles. The meeting agenda should give priority to stakeholders, service recipients, and family members. As in other states, DMH and state officers should assist stakeholders with accurate content developing for agenda items. Discussion and decisions made by the Mental Health Board, governor, legislators, and regarding grants or funding should be reported to the council via e-blast and as a meeting handout. Currently, the council meetings and reports provided are not necessarily delivered or presented to the Mental Health Board. A disconnect in communication could be repaired by doing this as well as a sharing of information and suggestions from the stakeholder's viewpoint. An update report of the DOJ lawsuit should be given regularly that includes the progress of the Special Master as well as the Mississippi attorney that was appointed as the Coordinator of Mental Health Accessibility via e-blast and/or handouts. Also, a subcommittee may request this information and be given the opportunity to make

remarks concerning progress made or what has been done, which would be reported at council meetings. The council should advise and make recommendations to the DMH Executive Director and the Mental Health Board regarding the council meetings. This does not include council meeting minutes as they note only core information and not open discussion. It should include questions that council members had and whether they were answered or unanswered and members statements that are relevant to the business of the Mental Health Board and legislation. The council should have a more tangible, transparent, and open communication process with the director and the Mental Health Board on the review and advise for its Strategic Plan. This must include a DMH council member and a consumer, advocate, or family member. For example, when presenting to the Mental Health Board about decisions made by the advisory council, subcommittees or agencies, at least one consumer, advocate or family member (representative of someone receiving services) will be present with the DMH council representative. With this two-prong approach, the professional and the person impacted thy those decisions will be able to interpret the boards decisions from both perspectives. Reporting recommendations should be sent directly to the governor and responses should be sent directly to council members to ensure open dialogue. This would allow the council to be the first people to make an assessment and tweak the information to safeguard against oversight or omission of impactful legislation. Use the federal judge's ruling as a priority guide for the council's agenda for discussions and planning. Legislation established says that the council does that. Also, make the council members aware of the guidelines. The council should receive updates on how CMHC's are using funding to meet Strategic Plan objectives and how the federal ruling objectives are being met as well. This would be helpful to the Special Master, the council, and those receiving services. The council should receive reports concerning how Peer Support staff are managed. This should include reports of harassment, manipulation, abuse or negligence in assistance with CPSS's training of the job they are hired to do. This includes the development of a formal report to be presented to the council listing the actual number and location of infractions while also keeping the CPSS's names confidential and a list of CMHC's who have CPSS's who work alone (which goes against the principle of Peer Support). This will enable DMH to provide support and technical assistance to the specific agencies. Reinstate new council member orientation to take place annually. Ms. Worsham has been on the council seven years and has never received orientation. She was added with no information and can see how it could be intimidating for others. It is important for retention and their ability to be empowered and be an integral part of the council. Council reports, decisions, and DMH program changes should be printed and publicly posted at CMHC's. This DMH information should include who and how to contact leaders regarding specific issues of concern or for further information. For example, a CMHC has a new CSU, Mobile Crisis Team or ICORT. This new information should be posted for everyone to see and someone listed as a contact person. This would keep us from spending a lot of money, time, and effort (especially with the difficulties of the pandemic) in getting information out to the public regarding available services in each region.

Ms. Bailey and Ms. Worsham have discussed the recommendations and Ms. Bailey thought that presenting them to the council would be beneficial. Previously there have

been subcommittees. A subcommittee may be an avenue to develop orientation and/or advance other recommendations.

Annual Report/Strategic Plan
Wendy Bailey – Mississippi Department of Mental Health
Administrative Services Deputy Director

FY2021-2023 was approved by the Board of Mental Health in July 2020. Both councils provided feedback in March 2020, regarding the plan. Based on that feedback, there were things incorporated into the plan. A copy of the plan was emailed to council members with this meeting invitation. The plan is on the DMH website as well. Ms. Bailey reviewed the changes and thanked the council for their input into the Strategic Plan.

Ms. Bailey reviewed the highlights of the DMH FY20 Annual Report. It can also be found on the DMH website.

Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health
Bureau of Administration Director

Mr. Breland reviewed the FY22 DMH Budget Request (PowerPoint) including institutional care spending vs. Community Services spending. The budget year begins July 1, 2021 and ends June 30, 2022. Requested funds are as follows: General $217,245,516, State Source Special $18,951,886, and Other Special Source $348,866,657. General funds requested include $5 million for community-based expansion ($1 million for adult mental health community-based services and $4 million for Medicaid/IDD Waiver for community-based IDD services). Total funding requested is $585,064,059.

Wrap Up/Proposed Dates and Topics for Next Meeting
David Connell, Chair – Mental Health P&A Council

The next meeting will be held in February 2021, probably virtually. However, further information will be sent to the council to confirm the meeting.

Announcements

Dr. Joe Kinnan complemented the NAMI state office for their great support and the continued push of information in creative ways. Hattiesburg commends and thanks the team at the state office. Hopes are to strengthen the NAMI system throughout the entire state in the new year.

Adjournment

Mr. Joe Grist adjourned the meeting at 11:35 a.m.

Mental Health and Substance Abuse Block Grant
Joint Planning & Advisory Council
Meeting Minutes
April 8, 2021

Present: KenYada Blake-Washington, Dr. Shawn Clark, David Connell, Kathy Crockett, Kay Daneault, Andrew Day, Carol Elrod, Jennifer Estes, Kevin Freeman, Annette Giessner, Joe Grist, Ronny Henderson, Jamie Himes, Dr. Joy Hogge, Pam Holmes, Jessica James, Dr. Joe Kinnan, Sandy Kinnan, Toniya Lay, Kennan LeSure, Harriette Mastin, Janet McCrory, Ben Mokry, Jan Moore, Alberto Nelson, Julie Powell, Kim Richardson, Sharon Robbins, Sonya Robinson, Terry Session, Tamara Stewart, Kambria Thorne, Gary Touchstone, Degarrette Tureaud, Larry Waller, Harold White, Nancy White, Dr. Scott Willoughby, Sitaniel Wimbley, Melody Worsham

DMH Staff Present: Wendy Bailey, Felita Bell, Misty Bell, Kelly Breland, Marcus Crowley, Dr. Eileen Ewing, Shane Garrard, Brent Hurley, Tressa Knutson, Dr. Mallory Malkin, Dr. LaTarsha Michael, Darlene Murphy, Chuck Oliphant, Julie Propst, Lynda Stewart, Katie Storr, Grenaye Sullivan, Melinda Todd, Carman Weaver, Belen White, Eric Wilson

Welcome and Meeting Overview – Shane Garrard

Mr. Garrard called the virtual meeting to order and welcomed everyone. He introduced Dr. Mallory Malkin, the new Director of the Bureau of Community Health Services at DMH.

The floor was then opened to Mr. Grist, A&D Council Chair.

Mental Health Council Comments

P&A Council Chair, Mr. Connell, thanked the council for their attendance.

Approval of Minutes

It was moved by Ms. Melody Worsham that the minutes from December 10, 2020, be approved. The motion passed.

Old Business

There was no old business.

New Business

New Transformation Transfer Initiative (TTI) Grants
Brent Hurley – Mississippi Department of Mental Health
Division of Adult Services Director

DMH was notified by the National Association of State Mental Health Program Directors in the fall of 2020 that grant funding was available through a project called Transformation Transfer Initiative. After applying, the grant was awarded and will end July 2021. DMH partnered with Pine Belt Mental Health to work with jails in Jones, Forrest, and Harrison counties emphasizing training correctional officers in the trauma informed care for individuals who may be experiencing mental illness or PTSD while they are incarcerated. This includes hiring and training Certified Peer Support Specialists in special forensics. This differs from the forensics training at MSH in that CPSS's are trained to help others navigate the justice system at any level (arrest, incarceration, or re-entry) and getting them reconnected with their community resources, similar to the Peer-Bridger Program. CPSS's will be working with corrections staff identifying individuals in need of mental health services. DMH has also partnered with Communicare in Region 2 to set up a Crisis Services Center. This will be a living room model (no overnight stays) crisis triage center serving as a single point of entry and providing services for individuals who are experiencing immediate crisis. This region has been working hard to establish CIT and jail diversion programs in the area. The obstacle has been securing a single point of entry. No hospitals have been willing to do so, which has been a common problem throughout the state. Multiple officers have been trained from the police departments in Oxford, Water Valley, and Senatobia and sheriff departments in Lafayette, Panola, and Marshall counties, as well as officers at Ole Miss. Both programs are still in the early stages, but these regions are working vigorously to get them started, established, and implemented. DMH hopes to work with these regions to continue these services after funding ends. Statistics should be available by the end of the summer showing how many individuals were diverted from the justice system and the sustainability of the program.

Mental Health Block Grant Update
Lynda Stewart – Mississippi Department of Mental Health
Division of Children and Youth Services Director

DMH is currently waiting for the guidance for the 2022/2023 Mental Health Block Grant application. DMH received additional one-time federal funding of approximately $20.5 million from SAMHSA ($12.9 million for substance abuse and $7.5 million for mental health). The funding must be utilized by March 15, 2023. This will allow the state to access mental health and substance abuse services for issues that are a direct result of the ongoing crisis of COVID-19. There has been a noted increase over the past year in calls to the DMH Helpline and the National Suicide Prevention Lifeline. Data from the DMH Helpline (over a period of 6 months) shows that there were 2,000 incoming calls since the pandemic began. During the same time, the National Suicide Prevention Lifeline received an increase of 875 calls. For questions, please contact Lynda Stewart at lynda.stewart@dmh.ms.gov.

Interagency Coordinating Council for Children and Youth (ICCCY)
Joy Hogge – Families as Allies
Executive Director

Families as Allies is a statewide organization run by and for families of children with behavioral health challenges. They support each other as family members and work together at the systems level for the benefit of Mississippi's children.

A System of Care (SOC) is the incorporation of many different services and support systems organized into a coordinated partnership with those receiving services. To simplify, FAA describes SOC work as a chocolate chip cookie. It is not any one ingredient. Its many different things, different identities, and different systems merging and having faced some heat together with each ingredient giving up its individual identity, yields something so much better than the sum of its parts. Normally this work is done from the perspective of families, and this would also be true of CPSS's receiving services, or people who have experienced those challenges in any system. Salt is always necessary in any recipe and that is true in SOC work. The people receiving services and their families must be at the table from the beginning otherwise it is not SOC work and will not be successful. The salt sometimes stings but that is what makes the other ingredients work better and produces the final product. In 2000, the SOC for children's mental health was started through state legislation. In 2010, it was strengthened. The Interagency Coordinating Council for Children and Youth (ICCCY) is the organization of those who oversee the actual services for children and youth. An example of an outcome of the council is MAP Teams. MAP Teams serve as the single point of entry for children with SED receiving services through multiple systems. These teams help them stay in the community by supporting their families, helping them if they go to residential treatment or acute care, and helping when they return. This is also important in early childhood, child psychiatry, etc. at the local level. The Interagency System of Care Coordinating Council (ISCC) consists of the state agencies providing services and supports. The ICCCY stopped meeting after 2012. The system has not had the coordination and oversight that it needs. This is something that the organization has worked on over the last 10 years. FAA and DMH have been working together and doing outreach to revive the ICCCY. They anticipate this happening within the next couple of months. Dr. Hogge would like for the ICCCY to evaluate Parent/Caregiver Peer Support implementation across systems, how children are supported from early childhood to transition age, and an integrated SOC for children with special healthcare needs in a healthcare system. There should not be two separate systems. The goal is to blend those and make sure all resources and block grants are being maximized. Meetings will be scheduled soon and will be open to the public and include public comments. FAA has designed a survey regarding the ICCCY, and everyone is encouraged to take it. The survey link was posted to the chat (http://survey.constantcontact.com/survey/a07ehom4xunkm10qhvu/start). To contact Dr. Hogge, email her at jhogge@faams.org. You do not have to understand all the legislation, just ideas of what would make things better for kids and their families in Mississippi. Dr. Hogge thanked Ms. Bailey publicly for her support and identifying this as a priority.

Ms. Bailey stated that the survey link has been shared on the FAA and DMH Facebook pages. She urged everyone to take the survey and reiterated that you do not need to have detailed understanding of the statute or even of the system, only issues that you think need to be addressed.

Proposed Mental Health 2021 Projects
Melody Worsham – Mental Health Association of South Mississippi

Due to technical issues, Ms. Bailey reviewed the information regarding the Proposed Mental Health 2021 Projects for Ms. Worsham.

The proposal was emailed to council members. Ms. Bailey and Ms. Worsham met regarding the recommendations and Ms. Bailey asked that the list be shared with the council. It was reviewed at the last meeting and the council has since been given time to read and process the information. It is a new year and there are many opportunities with this council that can be strengthened and developed. The advisory council falls under Dr. Malkin, Director of the Bureau of Community Health Services, and Mr. Garrard, Director of Alcohol and Drug Addiction Services.

Ms. Worsham asked that council members refer specifically to pages 12-14 of the Planning and Advisory Council Bylaws. If council members do not have the bylaws in easy reach, they can be shared via email. Ms. Worsham mentioned new member orientation, which is very important. Joining a new council can be overwhelming. It is important that an orientation is created for new members to truly understand the roles. Ms. Bailey stated that the key is reviving the subcommittees. The council meeting includes presenting and sharing of information, but the essential work can be done in subcommittees. Once they have been formed, the subcommittees will be able to look at projects presented as well as other projects that council members feel need further exploration. We can send out what subcommittees have previously been formed and see if anyone would like to serve on those. Ms. Worsham asked that those interested in subcommittees email her. We can do some of that back work before the next meeting. Another of Ms. Worsham's recommendations was sharing information with the Mississippi Board of Mental Health. This would involve a representative from the council presenting to the board. This has not really been done in the past, but Ms. Bailey wants to see it happen this year. This would enable the board to discover what is being done and the role that the council can play.

One of the positive things to come from COVID-19 is the use of technology and linking states together. Every two weeks, DMH participates in meeting calls with 11 southern state agencies. Last week Ms. Bailey and Mr. Hutchins asked for information regarding what other state planning and advisory councils are doing. Ms. Worsham's recommendations are right in line with other state activities. Ms. Bailey encouraged members to look at the project recommendations and provide some feedback. You can do that through email or through the council so it can be compiled and shared. Ms. Bailey hopes to see the council strengthened and utilization of the feedback received from the council.

Governor's Challenge
Katie Storr – Mississippi Department of Mental Health
Chief of Staff

Ms. Storr joined DMH in February 2021 as the Chief of Staff.

Mississippi was selected as one of eight states to participate in SAMHSA's Governors Challenge to prevent suicide among service members, veterans, and their families. As part of this acceptance, the governor has named Ms. Bailey as the Team Lead. There are 28 states who have participated in the past. We will be joining them to develop and implement statewide suicide prevention best practices through a partnership with a public health approach. The first meeting call was March 8, 2021, and some of the initiatives that have been done at DMH were discussed. DMH has also met with the members of Mississippi Veterans Affairs and the G.V. (Sonny) Montgomery VA Medical Center, who were also on the call. The teams have been compiled and consist of members from DMH, the Mississippi National Guard, Mississippi Veterans Affairs, the U.S. Department of Veterans Affairs, leadership from veteran military family and caregiver organizations, private sector providers, and Certified Peer Support Specialists. There is a pre-academy site visit scheduled for the end of the month and guidance is anticipated with the strategic initiatives moving forward. All team members will be meeting at this time and providing materials. The council will be provided with more information as this project advances.

Mental Health Budget Update
Kelly Breland – Mississippi Department of Mental Health
Bureau of Administration Director

Mr. Breland reviewed the tentative appropriation for FY2022 under Conference Report 2926 as sent to the Governor for signature. There are no issues expected and it should be back signed by April 22, 2021. There is an increase of $2,457,747 in General Funds, Healthcare Funds stayed the same, an increase of $600,000 in Capitol Expense Funds, and an increase of $43,612,744 in Special Funds. Much of this is request restoration of Special Funds. For example, when physicians stay vacant for a period time (90-180 days) the Joint Legislative Budget Committee has the mechanical process of going in and cutting the funding. Required funding specific in the appropriation is $1,000,000 for 83 Medicaid ID/DD Waiver (Home and Community Based Waiver) slots. The Capitol Expense Funds are earmarked for outpatient services to be provided from CMHC's to former inmates with mental health issues. The Capitol Expense Funds are among several funds that the legislature has the purview to appropriate through and these do not have to be specifically for the name of the fund. DMH had Capitol Expense Funds last in FY2015. Other information: The increase includes implementation of a 3% salary increase for employees in "Section 4." but this still needs clarification through the State Personnel Board. The SPB is currently putting a new system in place for evaluating and compensating employees. The increase also includes funding for health insurance increases that happened this past January. DMH also got a restoration of PINS that were previously cut by the Joint Legislative Budget Committee, which was the same mechanical process as above. These are not additional PINS. The PINS being cut did not affect CPSS's. Ms. Bailey stated that DMH is planning to add CPSS's at each CSU and increase CPSS's at Peer-Bridger Programs across the state. Special Funds include all funds other than General Fund sources (Healthcare, Capitol Expense and Other Special).

Wrap Up/Proposed Dates and Topics for Next Meeting

None

Dr. Ewing stated that she would let everyone know specifics about the next meeting as soon as she has them.

Announcements

Dr. Janet McCrory stated that she will be retiring from the Mississippi Institutions of Higher Learning as Director of Nursing Education on May 31, 2021. She thanked the council for allowing her to serve and for the work they do for the citizens of the state.

The NAMI Mississippi Virtual State Conference is May 26-29, 2021. Everyone is invited.

Adjournment

Mr. Joe Grist adjourned the meeting at 11:08 a.m.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kenyada Blake-Washington	State Employees	MS Department of Human Services	200 South Lamar Street Jackson MS, 39201 PH: 601-359-4909	kenyada.blake@mdhs.ms.gov
Mark Cheney	Others (Advocates who are not State employees or providers)	MS A&D Advisory Council	7070 Highway 80 Vicksburg MS, 39180 PH: 601-638-4784	
Shawn Clark	Providers	V A Medical Center	1500 E. Woodrow Wilson Avenue Jackson MS, 39216 PH: 601-362-4471	shawn.clark@va.gov
Amanda Clement	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	614 Eatonville Road Hattiesburg MS, 39401 PH: 601-297-7014	aclement123@gmail.com
David Connell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Behavioral Health Advisory Council Chair/Contact	44 Bates Lane Hattiesburg MS, 39402 PH: 601-520-1096	barbaque2004@yahoo.com
Chelsea Crittle	Providers	Central MS Planning and Development District	1020 Center Pointe Blvd. Pearl MS, 39208 PH: 601-981-1516	ccrittle@cmpdd.org
Kay Daneault	Providers	The Mental Health Association of South Mississippi	4803 Harrison Circle Gulfport MS, 39507 PH: 228-864-6274	kay@msmentalhealth.org
Andrew Day	State Employees	Division of Medicaid	550 High Street Jackson MS, 39201 PH: 601-359-6114	andrew.day@medicaid.ms.gov
Margaret Ellmer	State Employees	MS Department of Education	359 N.West Street Jackson MS, 39201 PH: 601-359-3498	margaret.ellmer@mdek12.org
Annette Geinesser	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self; Long Range Planning Committee	238 Sawbridge Drive Ridgeland MS, 39157 PH: 601-853-0815	bgeorgeg@att.net
			University of MS	

Maxie Gordon	Providers	MS Psychiatric Association	Medical Center Jackson MS, 39216 PH: 601-984-1000	maxiegordon@bellsouth.net
Lavonda Hart	State Employees	MS Department of Rehabilitation Services	P.O. Box 1698 Jackson MS, 39215 PH: 601-853-5270	lhart@mdrs.ms.gov
Ronney Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	V A Medical Center	211 Samuel Road Madison MS, 39110	ronney.henderson@va.gov
Jamie Himes	Providers	Southern Christian Services for Children and Youth	860 E. River Place Jackson MS, 39202 PH: 601-354-0983	jamie@southernchristianservices.org
Jessica James	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self/Peer Support	791 W. County Line Road Jackson MS, 39213 PH: 601-454-0507	jesspraise37@outlook.com
Joe Kinnan	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Mississippi - Pine Belt Affiliate	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)	NAMI Mississippi - Pine Belt Affiliate	204 Greenwood Place Hattiesburg MS, 39402 PH: 601-264-6994	jekin@comcast.net
Toniya Lay	Representatives from Federally Recognized Tribes	MS Band of Choctaw Indians	210 Hospital Circle Choctaw MS, 39350 PH: 601-384-4150	toniya.lay@choctaw.org
Harriette Mastin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		11880 Highway 61 South Vicksburg MS, 39180 PH: 601-630-9470	mastin8@juno.com
Ekoko Onema	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	111 Windward 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: 601-407-4783	jeco0650@gmail.com
Coreaner Price	Parents of children with SED/SUD	Families As Allies	840 E. River Place Jackson MS, 39202 PH: 601-355-0915	cprice@faams.org
Kim Richardson	State Employees	MS Bureau of Investigation	2200A Highway 35 N Batesville MS, 38606 PH: 662-563-6477	krichardson@dps.ms.gov
Tara Roberts	Parents of children with SED/SUD	Self/Youth Villages	58 Copperfield Court Jackson MS, 39206 PH: 601-918-5844	tara.roberts@youthvillages.org
Stephanie Stout	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self/AMPSS	916 West Chambers Booneville MS, 38829 PH: 662-416-5714	stephaniestout45@gmail.com

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	ttate@bellsouth.net
Wanda Thomas	Providers	Catholic Charities, Inc.	850 E. River Place Jackson MS, 39202 PH: 601-355-8634	wanda.thomas@ccjackson.org
Polly Tribble	State Employees	Disability Rights Mississippi	5 Old River Place, Suite 101 Jackson MS, 39202 PH: 601-968-0665	ptribble@drms.ms
Vacant Vacant	State Employees	MS Home Corperation	735 Riverside Drive Jackson MS, 39202 PH: 601-718-4611	
Larry Waller	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	11085 Old Dekalb Scooba Road Scooba MS, 39385 PH: 662-476-8035	tlwaller@bellsouth.net
Kay Warrington	State Employees	MS Insurance Department	P.O. Box 79 Jackson MS, 39205 PH: 601-359-2846	kay.warrington@mid.ms.gov
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 Mississippi State Hospital	823 Highway 589 Purvis MS, 39475 PH: 601-794-0241	swilloughby@smsh.state.ms.us
Sitaniel Wimbley	Others (Advocates who are not State employees or providers)	NAMI MS	2618 Southerland Street Jackson MS, 39216 PH: 601-899-9058	education@namims.org
Melody Worsham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	AMPSS/Self	6474 Florence Road Biloxi MS, 39532 PH: 228-864-6274	melody@msmentalhealth.org

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**36**	
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)	10	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**21**	**58.33%**
State Employees	8	
Providers	7	
Vacancies	0	
Total State Employees & Providers	**15**	**41.67%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	10	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**14**	
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 members of the Mississippi State Mental Health Planning and Advisory Council are provided with a draft of the application to review prior to the August Planning Council meeting and again during the public comment period. Council members are given the opportunity during prior to and during the public comment period to provide comments as well as request revisions to the Plan. The public comment period will be August 25, 2021 - September 14, 2021. At this point, no comments have been received from the Planning Council members.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

The URL link for the Draft copy of the FY 2022-23 Community Mental Health Services State Plan/MHBG Application is made available through emails to state agencies and organizations, the Mississippi State Planning and Advisory Council, and through a provider bulletin disseminated by the DMH Bureau of Certification and Quality Outcomes to all DMH certified providers. This URL link provides instant access to the the Plan placed on the DMH website. A request will also be made to have the link to the Plan placed on the DMH Facebook page. Mississippi Families As Allies also reports that the agency will share the link in their publication, The Ally. This URL link is below.

http://www.dmh.ms.gov/provider-documents/

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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Footnotes: