MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMMUNITY MENTAL HEALTH SERVICES FY 2020 – 2021 STATE PLAN

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SECTION I
STATE INFORMATION

FACE SHEET COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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

Agency Name: Mississippi Department of Mental Health

Organizational Unit: Bureau of Behavioral Health Services

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

City: Jackson

Zip Code: 39201

II. Contact Person for the Grantee of the Block Grant

First Name: Diana

Last Name: Mikula

Agency Name: 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: diana.mikula@dmh.ms.gov

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

From: ***7/1/2018***

To: ***6/30/2019***

IV. Date Submitted

Submission Date: ***9/3/2019***

Revision Date:

V. Contact Person Responsible for Application Submission

First Name: Jake

Last Name: Hutchins

Telephone: 601-359-1288

Fax: 601-359-6295

Email Address: jake.hutchins@dmh.ms.gov

PHIL BRYANT
GOVERNOR

September 1, 2015

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

Dear Ms. Simmons:

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

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

Sincerely,

Phil Bryant
GOVERNOR

State Information

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

Fiscal Year 2020

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: Diana S. Mikula

Signature of CEO or Designee[1]: Diana S. Mikula

Title: Executive Director Date Signed: 07/30/19

mm/dd/yyyy

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

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

Footnotes:

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
MISSION STATEMENT

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance use problems and intellectual/developmental disabilities one person at a time.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
VISION STATEMENT

We envision 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.

A better tomorrow exists when…

- All Mississippians have equal access to quality mental health care, services, and supports in their communities.
- People actively participate in designing services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance use, and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

Philosophy of the Department of Mental Health

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service and support options for adults and children with mental illness or emotional disturbance, alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The DMH supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. The DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. The DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-centered, community-based, results and recovery/resiliency oriented.

Core Values and Guiding Principles of the Department of Mental Health

People: We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice, and provision of services to meet their unique needs.

Community: We believe the community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

Commitment: We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

Excellence: We believe services and supports must be provided in an ethical manner, meet established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

Accountability: We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

Collaboration: We believe that services and supports are the shared responsibility of state and local governments, communities, families, and service providers. Through open communication, we continuously build relationships.

Integrity: We believe the public mental health system should act in an ethical and trustworthy manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

Awareness: We believe awareness, education, prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

Innovation: We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

Respect: We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the mental health system.

SECTION II
PLANNING STEPS

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 Bureau of Administration works in concert with all Bureaus to administer and support development and administration of mental health services in the state. The Bureau oversees the accounting/payroll, auditing, and grants management functions of the agency. Information Systems is also a part of the bureau.

The Bureau of Behavioral Health Services 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 three areas including State-Operated Programs, Community Mental Health Services, and Addictive 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.

The Bureau of Certification and Quality Outcomes is responsible for ensuring the safe provision of high quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes three divisions: Certification, Incident Management, and Professional Licensure and Certification (PLACE).

The Bureau of Human Resources is responsible for employment and workforce development. Such matters include all aspects of human core capital processing, recruitment, retention,

benefits, worker's compensation, job performance monitoring, and discipline. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for people in the state with intellectual and developmental disabilities. The service delivery system is comprised of the State-Operated Programs, 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 Outreach and Planning is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also oversees all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects.

Functions of the Mississippi Department of Mental Health

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

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

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

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

and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

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

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

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

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

Administration of Community-Based Mental Health Services

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

interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in, and/or facilitates numerous avenues for ongoing communication with consumers, family members, and services providers.

State Mental Health Agency's Authority in Relation to Other State Agencies: The DMH is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance use services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan. 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 Rita Berthay, 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 Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347

Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)
Region 9: Hinds	Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director 3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Russ Andreacchio, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	A Clear Path: Southwest Mississippi Behavioral Health Sherlene Vince, Executive Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Mona Gauthier, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Vickie Taylor, Interim Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Behavioral Health, Inc. Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Strengths and Needs of the Service System

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

- DMH was awarded a four year System of Care Expansion and Sustainability Agreement beginning September 30, 2017. Two local community mental health center regions are implementing the program in five counties that targets 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 provides evidence based practices; training for professionals, youth and their families; and, resources and informal supports to youth enrolled in the program.

- 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. Another example is the long-term collaboration of the DMH and the Department of Child Protection Services (CPS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services.

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

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. The DMH continues to fund ten CMHCs for the provision of mental health services in the local detention centers. Services include assessments, Community Support Services, SPARCS (group therapy), Cognitive Behavioral Therapy (CBT), Wraparound Facilitation, and medication monitoring as well as training of juvenile detention center staff.

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

- Through an initiative with NAMI MS, DMH along with several CMHCs and 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 psychiatric episode. DMH added three (3) additional NAVIGATE teams for a total of five (5) 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.

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

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

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

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

- Expand intensive home- and community-based services, such as the Division of Medicaid's MYPAC program, to additional providers in the state. Mississippi Youth Programs Around the Clock (MYPAC) is an all-inclusive home and community- based program that assists children and youth up to the age of twenty-one (21) with serious emotional disturbance (SED) in gaining access to needed mental health services. The MYPAC program follows the high fidelity Wraparound process and is offered as an alternative to traditional Psychiatric Residential Treatment Facilities (PRTF).

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

appropriate services

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

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

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

- The DMH funds eight (8) 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

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

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

- The 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 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.

- The DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. The sites are in Regions 2, 7, 10, and 12. New Supported Employment sites are Regions 3, 4, 8, 9, 11, 14, and 15 with a goal of offering supported employment to 175 individuals 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 continues to provide Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members. ASIST is a 2–day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.

- Mississippi has ten (10) Programs of Assertive Community Treatment Teams (PACT) that serve the following counties: Region 3 (serves Lee County), 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 and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

- The Specialized Planning Options to Transition Team (SPOTT) is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the

expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.

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

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

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

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

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

- The DMH is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. The DMH makes 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. The goal of this one day training is to reduce disparities in access to public and community services through the provision of culturally and linguistically appropriate services. DMH also received technical assistance regarding cultural and linguistic competence from The Department of Child &Family Studies (CPS) at the University of South Carolina 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.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service System

Adults

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

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

Crisis Stabilization Units
The DMH funds eight 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

Housing
The Creating Housing Options in Communities for Everyone (CHOICE) program is funded by the State of Mississippi. It is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and Mississippi's Community Mental Health Centers. The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance, with supportive mental health services through Integrated Supportive Housing.

Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program.

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

Supported Employment
The DMH utilized legislative appropriated community expansion general funds to provide 4 pilot program sites (Regions 2,7,10, and 12) to begin implementation of supported employment services for adults living with mental illness in Mississippi. The DMH collaborates with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental illness. Currently, in addition to the 4 pilot sites initially funded, supported employment is now being provided in Regions 3,4,8,9,11,14,and 15.

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 14 of our CMHC's.

Psychosocial Rehabilitation Services (PSR)
Psychosocial Rehabilitation Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. PSR is a core service and is offered at the 14 CMHCs and five (5) private providers.

Recovery Supports
The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented. Recovery Supports include Certified Peer Support Specialists who are employed by DMH certified programs to work with individuals receiving services in achieving their hopes, dreams, and goals, assist the DMH Certification Team in conducting certification visits of DMH certified providers, and provide training in conjunction with DMH staff on Recovery-Oriented System of Care. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Personal Outcome

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

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

Children and Youth

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 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 2017 is 370,504. Mississippi remains in the group of states with the highest poverty rate (27.7% age 5–17 in poverty, based on URS Table 1). Therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2017 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 40,755 – 48,166

- 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 25,935– 33,345

Adults

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi in 2017. URS Table 1 reports that there are 2,257,249 adults in Mississippi (ages 18 years +). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2017, ages 18 years and above, is 121,891 with a lower limit estimate of 83,518 and an upper limit estimate of 160,265.

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 2018 (DMH Annual Surveys, FY 2018). 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 2018	37,441	66,359

Criterion 3: Children's Services

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

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 14 community mental health/IDD commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, intensive home/community-based services, family education and prevention/early intervention services. Public inpatient services are provided directly by the DMH (described further later under this criterion). The DMH remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State-Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Mobile Crisis/Emergency Response Teams, Medication Maintenance, Intensive Home/Community Based Services, Wraparound Facilitation, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early and Periodic Screening and Diagnostic Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group, and psychological and developmental evaluations.

Interagency Collaboration for Children and Youth with SED

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

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Child Protection Services, Department of Health, Department of Education, the Attorney General's Office, Families As Allies for Children's Mental Health, Inc., 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 14 community mental health regions across the state.

The Executive Steering Council acts as the Executive Council for the Mississippi System of Care Grants, Mississippi State Youth Treatment Enhancement and Dissemination Project (SYT-ED) and other grants, as approved by the ESC, to provide technical assistance and guidance to the local project sites; and to provide leadership for the management and operation of the projects. In addition to other tasks, this committee meets monthly and participates on the subcommittees of the Statewide Affinity Group, ensures that effective support and technical assistance are provided to the grantee, votes on budget issues, and advocates on a youth's behalf or on behalf of other youth and families who may not have found their voice. Membership of the council 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 four nationally certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. In addition, the Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral

Therapy (TF-CBT). DMH trainers provide trainings upon request to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. In June 2017, the first group of Mental Health First Aid trainers received supplemental training on the Mental Health First Aid for Law Enforcement, Corrections, and Public Safety module. This module builds upon the effectiveness of the standard Mental Health First Aid curriculum by focusing on the unique experiences and needs of law enforcement, corrections and public safety audiences. In June and July 2018, DMH partnered with local Community Mental Health Centers to offer 17 MHFA for Youth trainings to educators across the state free of charge. More than 260 educators participated in these trainings. 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 will provide training in Mental Health First Aid for Youth to educators and parents. In FY 2017 and FY 2018, Division of Children and Youth Services staff completed four (4) A.S.I.S.T. trainings and six (6) CIT trainings across the state to public schools, law enforcement officers, state agency employees, and institutions of higher learning. Three Division of Children and Youth staff continues to maintain their certification as A.S.I.S.T. Trainers.

Integrated Services for Children and Youth with SED

Initiatives to Assure Transition to Adult Mental Health Services

The Division of Children and Youth Services, the Division of Adult Community Services, and the Division of Alcohol and Drug Services have made a concerted effort to better address issues of youth transitioning from the child to the adult system. The Executive Steering Committee has focused on expanding the age range of children/youth identified as transitional–age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Council has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. DMH currently funds 3 sites that target transition–aged youth. Most recently, another 4-year grant that targets youth in the child welfare system and/or juvenile justice system was awarded.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services for transitional living programs that 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
The Division of Children and Youth Services partners with the Division of Alcohol and Drug Services to fund and implement Adolescent Intensive Outpatient Programs serving youth with co-occurring disorders utilizing evidence-based practices such as Adolescent Community Reinforcement Approach, Wraparound Facilitation and the GAIN assessment system. Additionally, the Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance use problems which also address problems of youth with co-occurring disorders.

Criterion 4: Targeted Services to Rural and Homeless Populations

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

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

Criterion 5: Management Systems

Federal Block Grant Award FY 2019	
Administration Amount	$298,682
Set Aside	$800,000
Amount to be awarded	$6,272,319
Children's portion	$2,360,006
Adult portion	$2,813,631

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. Since FY10, DMH has utilized a goal-based strategic plan to transform the public mental health system in Mississippi. The FY19 – FY21 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 were used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing were identified. As part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided the DMH with state level population data and various indicators of poverty and disability. While there continues to be a need for transportation and housing for targeted groups, the information and data provided by TAC has been used on occasions to educate public officials, stakeholders, and

funding sources regarding the need for expanding and increasing transportation and housing. The TAC data has also been used to develop applications for funding to increase these services.

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

The Division of Children and Youth Services gains information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, 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 2019 – 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. Mississippi's rankings are as follows:

- 37th for Adults with highest prevalence of mental illness and lowest rates of access to care (Mississippi
- 11th for Adults with any mental illness (Mississippi: 17.49% National: 18.07%)
- 10th for Adults with serious thoughts of suicide (Mississippi 3.78% National: 4.04%)
- 46th for Adults any mental illness and uninsured (Mississippi: 18.0% National: 12.2%)
- 51st for Adults with Disability who could not see a Doctor due to costs (Mississippi: 30.91% National: 21.62%)
- 46th in mental health workforce availability

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 (MCeRT) and Programs of Assertive Community Treatment (PACT), the development of Intensive Community Outreach Recovery Teams ((iCORT), and through the expansion of Crisis Intervention Teams (CIT) across the state.

According to the Behavioral Health Barometer, Mississippi 2017 Report, between 2013-2017, 26,000 Mississippi adolescents, ages 12 to 17 (10.7% of all adolescents) had at least one Major Depressive Episode (MDE). Statistically, Mississippi's data is similar to both the regional average (11.1%) and the national average (12.1%). Approximately 9,000 adolescents, ages 12-17, with Major Depressive Episode (34.4% of all adolescents with MDE in Mississippi) received treatment for their depression, which is similar to both the regional average (38.0%) and the national average (40.3%) during the years of 2013-2017.

During 2013–2017, the annual average prevalence of past-year SMI experienced by young adults in Mississippi (ages 18-25) was 4.1% (or 14,000), similar to both the regional average of 4.8% and the national average of 5.5%. (Behavioral Heath Barometer, 2017).

In, *Mental Health in America 2019 – Ranking the States* (Mental Health America, 2019) the following information is reported on Mississippi's rankings compared to other states:

- 48th for youth ranking with the highest prevalence of mental illness and lowest rates of access to care
- 25th for children with youth with severe Major Depressive Disorder (Mississippi: 8.9% National: 8.7%)
- 5th for youth with at least one Major Depressive Episode (Mississippi: 10.78% National: 12.6%)
- 24th for students identified with Emotional Disturbance for an Individualized Education Program (Mississippi 7.88% National: 7.36%)
- 43rd for children who needed but did not get mental health services (Mississippi: 67.1% National: 61.5%)
- 51st for children reporting inadequate insurance (Mississippi: 21.9% National: 7.8%)
- 46th in mental health workforce availability

Evidenced by the statistics above, access to care is an identified challenge for Mississippi's youth based on the high prevalence rate of emotional and behavioral issues. The DMH has worked diligently to increase the number of qualified providers and to expand services/programs across the state. From January 2011 to September 2018, ten (10) new providers in Mississippi have been certified by DMH to provide the Core Services to children and youth with SED. Fourteen (14) providers are certified to provide Wraparound Facilitation and nine (9) providers are certified to provide Intensive Outpatient Psychiatric Services for Children and Youth with SED, formerly known as MYPAC (Mississippi Youth Programs Around the Clock, a grant funded program initially offered by the Division of Medicaid).

Step 3: Prioritization of State Planning Activities

Table 1 **Plan Year FY 2018-2019:**

	Priority Areas
1	Peer Support
2	Community Supports for Adults
3	Crisis Services
4	Supported Housing
5	Community Supports for Children
6	Community Integration
7	Supported Employment
8	Recovery Supports
9	Evidence-Based Practices

Step 4: Objectives, Strategies and Performance Indicators

The primary target populations addressed in the FY 2020-2021 State Plan are children with serious emotional disturbances (SED) and adults with serious mental illness (SMI).

***The following goals are not exclusively funded by federal block grant dollars.**

Priority Area 1	Peer Support
Priority Type	MHS
Population	SMI, SED
Goal 1	Enhance the transition process of individuals to a less restrictive environment
Objective 1	Continue to utilize Peer Bridgers to improve the process for people transitioning from inpatient care to community-based care
Strategies	Utilize Peer Bridgers at a behavioral health program and local Community Mental Health Centers utilizing WRAP
Indicator	Number of Peer Bridgers
Baseline Measurement	In FY 2016: 5 (No data for FY 15 – Pilot Project)
First Year Target/Outcome Measurement	In FY 2020: 5
Second Year Target/Outcome Measurement	In FY 2021: 5
Data Source	Data is collected quarterly by the 3 local CMHCs and the behavioral program and submitted to DMH.
Description of Data	Quarterly data collected includes number of Peer Bridgers employed by and tracked by the grantees which are a behavioral program and 3 local CMHCs. Each of the 3 CMHCs has a full-time Peer Bridger and the behavioral program has two part-time Peer Bridgers. Services provided by Peer Bridgers will help individuals transition back into their communities and avert future potential crises.

Priority Area 1	Peer Support
Priority Type	MHS
Population	SMI, SED
Goal 2	Utilize individuals with lived experience of mental illness and/or substance use and parent/caregivers to provide varying supports to assist others in the journey to recovery and resiliency.
Objective 1	Increase the number of individuals with lived experience of mental illness and/or substance use and parent/caregivers certified as Peer Support Specialists (CPSS)
Strategies	• Conduct outreach to stakeholders to increase the number of CPSS and the role of CPSSs • Provide training and technical assistance to service providers on the Recovery Model, Person Centered Planning, and System of

	Care Principals. • Provide training to CPSS Supervisors on recruitment, retention, and supervision of CPSSs
Indicator	Number CPSSs employed by DMH certified providers
Baseline Measurement	In FY 2015: 36
First Year Target/Outcome Measurement	In FY 2020: 253
Second Year Target/Outcome Measurement	In FY 2021: 278
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 Certified Peer Support Specialists. In FY 2018, 230 Certified Peer Support Specialists were employed by DMH certified providers.

Priority Area 2	Community Supports for Adults
Priority Type	MHS
Population	SMI
Goal 1	Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements
Objective 1	Utilize Programs of Assertive Community Treatment (PACT) Teams to help individuals who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient services
Strategies	Increase the number of admissions to PACT Teams
Indicator	Number of admissions to PACT Teams
Baseline Measurement	In FY 2015: 97
First Year Target/Outcome Measurement	In FY 2020: 200
Second Year Target/Outcome Measurement	In FY 2021: 225
Data Source	All ten (10) PACT Teams submit data quarterly to DMH. Data includes number of admissions to PACT Team services.
Description of Data	Quarterly data is submitted by the eight PACT Teams. Data includes number of admissions. During FY 2018, there were 140 new admissions to PACT Teams with 384 individuals being served.

Priority Area 2	Community Supports for Adults
Priority Type	MHS
Population	SMI
Goal 2	Provide funding to offset cost of mental health services provided to

	individuals with serious mental illness who have no payer source
Objective 2	Provide services through the Purchase of Services Grant
Strategies	Grant funding to 14 CMHCs for Purchase of Services
Indicator	Number of units of service reimbursed by Purchase of Service Grant
Baseline Measurement	In FY 2015: 180,002
First Year Target/Outcome Measurement	In FY 2020: Maintain the number of units of service
Second Year Target/Outcome Measurement	In FY 2021: Maintain the number of units of service
Data Source	The 14 CMHCs submit data monthly through cash requests and monthly reports. This data includes number of units of services provide through the POS grants. Number of units of services reimbursed cannot be increased without an increase in funding.
Description of Data	Data is collected through monthly cash requests and submitted by the 14 CMHCs/grantees.

Priority Area 3	Crisis Services
Priority Type	MHS
Population	SMI, SED
Goal 1	Divert individuals from more restrictive environments such as jail and hospitalizations by utilizing Mobile Response Teams.
Objective 1	Expand access to crisis services through the utilization of Mobile Crisis Response Teams
Strategies	Increase the number of contacts/calls made by the Mobile Crisis Response Teams
Indicator	Number of contacts
Baseline Measurement	In FY 2015: 19,660
First Year Target/Outcome Measurement	In FY 2020: 27,000
Second Year Target/Outcome Measurement	In FY 2021: 28.000
Data Source	The number of emergency calls and contacts responded to by the Mobile Crisis Response Teams is submitted to DMH two times per year.
Description of Data	Data is submitted two times per year by the Mobile Crisis Response Teams to DMH. In FY 2018, at total of 26,322 calls were received and there were a total of 18,651 face-to-face visits.

Priority Area 3	Crisis Services
Priority Type	MHS
Population	SMI, SED
Goal 1	Expand access to crisis services to divert individuals from more

	restrictive environments such as jails, hospitals, etc.
Objective 2	Expand access to crisis services through the utilization of Crisis Stabilization Units
Strategies	Track the number of admissions to the Crisis Stabilization Units
Indicator	Number of admissions
Baseline Measurement	In FY 2015: 3,609
First Year Target/Outcome Measurement	In FY 2020: 3,500
Second Year Target/Outcome Measurement	In FY 2021: 3,600
Data Source	Quarterly data, which includes number of admissions, is submitted by the CSUs to DMH.
Description of Data	Crisis Stabilization Units submit data quarterly to DMH which includes the number of involuntary and voluntary admissions. In FY 2018, the CSUs served 3,513 individuals.

Priority Area 4	Supported Housing
Priority Type	MHS
Population	SMI
Goal 1	Connect adults with serious mental illness to appropriate housing opportunities
Objective 1	Increase the availability of community supports/services for people with a serious mental illness in order to implement Supportive Housing
Strategies	Ensure that people with a serious mental illness who are 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
Indicator	Number of assessments provided; number of individuals maintained in supportive housing
Baseline Measurement	In FY 2016: 48 assessments provided; 48 individuals maintained in supportive housing
First Year Target/Outcome Measurement	In FY 2020: 200 assessments provided; 200 individuals maintained permanent supportive housing
Second Year Target/Outcome Measurement	In FY 2021: 300 assessments provided; 300 individuals maintained permanent supportive housing
Data Source	The six CMHCs operating CHOICE programs submit quarterly data to DMH.
Description of Data	Data will be submitted quarterly to DMH to include the number of assessments provided and the number of individuals maintained in Supportive Housing. The CHOICE program began in March 2016 with programs being operated by six CMHCs. The CHOICE program is currently available in all CMHC regions, and in FY 2018, 211 assessments were provided. 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 .

Priority Area 5	Community Supports for Children
Priority Type	MHS
Population	SED
Goal 1	Utilize MAP Teams to help serve children and youth in their community and prevent unnecessary institutionalizations
Objective 1	Increase the participation of local representatives from CPS, school districts, and juvenile justice on MAP Teams
Strategies	Technical assistance will be provided to MAP Teams as requested and/or needed.
Indicator	Number of representatives from CPS, school districts, and juvenile justice attending MAP teams quarterly
Baseline Measurement	In FY 2019: New indicator. Baseline data gathered.
First Year Target/Outcome Measurement	In FY 2020: Projections regarding outcomes will be made once baseline data has been gathered.
Second Year Target/Outcome Measurement	In FY 2021: Projections regarding outcomes will be made once baseline data has been gathered.
Data Source	Data, including local partners present at MAP Teams, are submitted quarterly to DMH by the MAP Team Coordinators.
Description of Data	Local partners sign-in at each monthly meeting by name and group affiliation or agency represented. Quarterly reports are submitted to DMH by MAP Team Coordinators which compile the information from monthly sign in sheets.

Priority Area 5	Community Supports for Children
Priority Type	MHS
Population	SED
Goal 2	Increase statewide use of Wraparound Facilitation with children and youth
Objective 1	Increase the number of children served by Wraparound Facilitation
Strategies	Increase statewide use of Wraparound Facilitation with children and youth through training and supports provided by the Mississippi Wraparound Institute.
Indicator	Number of children served by Wraparound Facilitation
Baseline Measurement	FY 2015: 1,078
First Year Target/Outcome Measurement	FY 2020: 1,775
Second Year Target/Outcome	FY 2021: 1,800

Measurement	
Data Source	Data which includes the number of children and youth served with Wraparound Facilitation is submitted quarterly to DMH by MWI.
Description of Data	A total of 12 providers were certified to provide Wraparound Facilitation in FY 2018, and a total of 535 individuals were trained. The Mississippi Wraparound Institute (MWI) employs nationally certified Wraparound coaches in the state to provide training and supports to certified providers of Wraparound Facilitation in Mississippi. Data is submitted quarterly to DMH by MWI. In FY 2018, 1,329 children and youth were served with Wraparound Facilitation.

Priority Area 5	Community Supports for Children
Priority Type	MHS
Population	SED, ESMI
Goal 3	Assist youth and young adults in navigating the road to recovery from First Episode Psychosis (FEP), including efforts to function well at home, on the job, at school and in the community through the Coordinated Specialty Care Team
Objective 1	Increase the number of youth and young adults experiencing FEP served through the NAVIGATE Program.
Strategies	Continue an evidenced-based intervention program for youth and young adults who have experienced FEP
Indicator	Number of youth and young adults served through NAVIGATE
Baseline Measurement	In FY 2016: 4
First Year Target/Outcome Measurement	In FY 2020: 70
Second Year Target/Outcome Measurement	In FY 2021: 75
Data Source	Number of youth and young adults experiencing FEP served through the NAVIGATE Program is submitted monthly to DMH by the two CSC teams.
Description of Data	NAVIGATE assists individuals, 15-30 years of age, who have experienced their first episode of psychosis. DMH funds the program at Life Help, Hinds Behavioral Health Services, Warren Yazoo Behavioral Health, and Gulf Coast Mental Health Center. In FY 2018, CSC Teams served 23 young adults. Region 8 will begin providing NAVIGATE services in FY 2019. Data is submitted monthly to DMH by the CSC teams which includes the number of youth and young adults served through the NAVIGATE Program.

Priority Area 5	Community Supports for Children
Priority Type	MHS
Population	SED
Goal 4	Provide services through the Juvenile Outreach Program (JOP) that are

	necessary for a youth's successful transition from a detention center back to his/her home and/or community
Objective 1	Decrease the number of re-entries to the detention centers
Strategies	Continue funding to CMHCs to make mental health services available to youth in detention centers in an effort to prevent re-entries
Indicator	Number served in detention centers
Baseline Measurement	FY 2018: 1,760
First Year Target/Outcome Measurement	FY 2020: 1,800
Second Year Target/Outcome Measurement	FY 2021: 1,850
Data Source	Data is submitted monthly by the CMHCs receiving 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. In FY 2018, 1760 youth were served by JOP Programs.

Priority Area 6	Community Integration
Priority Type	MHS
Population	SMI
Goal 1	Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements
Objective 1	Develop Intensive Community Outreach Recovery Teams (iCORT) for adults with severe and persistent mental illness
Strategies	Utilize iCORTs to keep people in the community and avoid placement in state hospitals
Indicator	Number of iCORTs operating and number of admissions to iCORTS
Baseline Measurement	In FY 2020: New objective. Five CMHCs will operate iCORTS. Baseline data regarding number served will be gathered in FY 2020.
First Year Target/Outcome Measurement	In FY 2021: Projections regarding outcomes will be made once baseline data has been gathered.
Data Source	Data regarding number of iCORTS operating and number of admissions to iCORTS will be submitted quarterly to the Division of Adult Services.
Description of Data	Regions 1, 2, 7, 11, and 14 will operate Mississippi's first iCORTS for adults with severe and persistent mental illness to help people remain in the community and avoid placement in state hospitals. The Division of Adult Services will collect the data regarding number served on a quarterly basis from the five (5) CMHCs operating iCORTS.

Priority Area 7	Supported Employment
Priority Type	MHS
Population	SMI
Goal 1	Develop employment options for adults with serious and persistent mental illness
Objective 1	Increase the number of individuals with serious and persistent mental illness who are gainfully employed
Strategies	• Expand employment options for adults with serious and persistent mental illness by increasing referrals. • Collaborate with Vocational Rehabilitation Services
Indicator	Number of individuals who are gainfully employed; Number of referrals made to MDRS
Baseline Measurement	In FY 2016: 102 (four program sites)
First Year Target/Outcome Measurement	In FY 2020: 250 individuals employed; 175 referrals made to MDRS
Second Year Target/Outcome Measurement	In FY 2021: 300 individuals employed; 180 referrals made to MDRS
Data Source	Supported Employment programs submit data quarterly to DMH including the number of individuals with serious mental illness who are employed and number of referrals made to MDRS.
Description of Data	As of June 2019, supported employment is provided in Regions 2,3,4,7,8,9,10,11,12.14,and 15 These sites submit data quarterly to DMH including the number of individuals with serious mental illness who are employed. In FY 2018, supported employment programs assisted 257 individuals on their road to recovery by helping them to become employed in the openly competitive job market.

Priority Area 8	Recovery Supports
Priority Type	MHS,
Population	SMI, SED
Goal 1	Strengthen family education and family support capabilities in the state
Objective 1	Increase recovery supports to people through family education and family support provided NAMI-MS funded by DMH
Strategies	Provide a variety of training and workshops targeting people with SMI and family members of children/youth with SED throughout the state
Indicator	Number of training and workshops
Baseline Measurement	In 2015: 110 workshops/support groups/trainings were conducted by NAMI
First Year Target/Outcome Measurement	In 2020: 135
Second Year Target/Outcome Measurement	In 2021: 140
Data Source	The number of trainings and workshops provided by NAMI-MS to

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

Priority Area 8	Recovery Supports
Priority Type	MHS
Population	SMI, SED
Goal 2	Expand the peer review/quality assurance process by utilizing Personal Outcome Measures (POM) interviews to measure outcomes of individuals receiving services
Objective 1	Improve access and outcomes of services to people receiving services through data gathered in POM interviews
Strategies	Offer technical assistance to providers after POM reports are released to providers.
Indicator	Number of visits to conduct POM interviews at CMHCs
Baseline Measurement	In FY 2015 and FY 2016: 350
First Year Target/Outcome Measurement	In FY 2020: 8 POM interview visits
Second Year Target/Outcome Measurement	In FY 2021: 8 POM interview visits
Data Source	The number of Personal Outcome Measure (POM) visits to the CMHCs will be tracked and submitted to DMH quarterly.
Description of Data	The number of Personal Outcome Measure (POM) Interview visits completed during each certification visit to the CMHCs will be tracked and submitted to DMH quarterly. Certified Peer Support Specialists participate on the Certification Visit Team and conduct the interviews during scheduled certification visits. Results of the POM interviews are released to the provider and technical assistance is offered based on the results of the report.

Priority Area 6	Community Integration
Priority Type	MHS
Population	SMI
Goal 1	Enhance the transition process of people to a less restrictive environment
Objective 1	Assist patients in 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
Strategies	Strengthen the utilization of Wellness Recovery Action Plans at the

	behavioral health programs to help patients identify and understand their personal wellness resources
Indicator	Number of Wellness Recovery Action Plans begun prior to discharge
Baseline Measurement	In FY 2019: 338
First Year Target/Outcome Measurement	In FY 2020: 400
Second Year Target/Outcome Measurement	In FY 2021: 500
Data Source	Data is submitted by the behavioral health programs to DMH on a quarterly basis.
Description of Data	The number of Wellness Recovery Action Plans begun prior to discharge at the behavioral health programs is submitted quarterly to DMH. Wellness Recovery Action Plans (WRAP) is part of the transition process, which provide people with a self-directed wellness tool upon discharge to support the individual as he/she transitions from a higher level of treatment into a more integrated treatment setting in the community. A total of 338 WRAPs were conducted at the pilot program (NMSH).In addition, SMSH conducted 364 WRAPS.

Priority Area 9	Evidence-Based Practices
Priority Type	MHS
Population	SED
Goal 1	Provide trainings in evidence-based and best practices to a variety of stakeholders
Objective 1	Increase the number of parents, school professionals, and School Resource Officers trained in Youth Mental Health First Aid
Strategies	Offer Youth Mental Health First Aid to school personnel, parents, and School Resource Officers through partnerships with CMHCs and Mississippi Department of Education
Indicator	Number of YMHFA trainings
Baseline Measurement	In FY 2019: 28
First Year Target/Outcome Measurement	In FY 2020: 45
Second Year Target/Outcome Measurement	In FY 2021: 45
Data Source	Trainings conducted are submitted monthly by certified YMHFA trainers within the DMH and across the state on a monthly basis.
Description of Data	This data is collected by the Bureau of Outreach and Planning which oversees all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects. Trainings conducted are submitted on a monthly basis by trainers certified in YMHFA.

Priority Area 9	Evidence-Based Practices
Priority Type	MHS
Population	SMI
Goal 1	Provide trainings in evidence-based and best practices to a variety of stakeholders
Objective 1	Increase the number of law enforcement officers trained in Crisis Intervention Team Training
Strategies	Partner with stakeholders to expand Crisis Intervention Team Training
Indicator	Number of officers trained in CIT
Baseline Measurement	In FY 2019: 170
First Year Target/Outcome Measurement	In FY 2020: 175
Second Year Target/Outcome Measurement	In FY 2021: 180
Data Source	At the conclusion of each CIT Training, a list of graduates is submitted to DMH by the seven counties providing CIT.
Description of Data	The 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).

SECTION III
PLANNED EXPENDITURES

Table 2 State Agency Planned Expenditures

Activity	Substance Abuse Block Grant	Mental Health Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds (e.g., ACF(TANF) CDC, CMS (Medicare, SAMHSA, etc.)	State Funds	Local Funds (excluding local Medicaid)	Other
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		$229,425					
3. Evidence – based Practices for ESMI (10% Set aside)		$800,000					
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$10.000.000	$6,500,000	$75,000,000		$10,000,000

7. Other 24 hour care			$8,000,000		$26,256,489		
8. Ambulatory/ Community Non-24 hour care		$4,944,212	$140,000,000	$3,261,540	$25,277,980		
9. Administration		$298,682		$100,000	$1,780,000		$25,000
10. Subtotal (1,2,3,4,9)							
11. Subtotal (5,6,7,8)							
12. Total		$6,272,319	$158,000,000	$9,861,540	$128,314,469		$10, 025,000

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

Activity	MHBG
1. Information Systems	$0
2. Infrastructure support	$0
3. Partnerships, community outreach, and needs Assessment	$0
4. Planning Council Activities	$0
5. Quality Assurance and Improvement	$50,000
6. Research and Evaluation	$0
7. Training and Education	$180,000
8. Total	$230,000

SECTION IV
NARRATIVE PLAN

The Health Care System, Parity, and Integration

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.

Formerly, integrated mental health, substance use and primary health care services were not all available at the same location on a statewide basis. However, in 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care. IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc. Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care. Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association. Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue. In 2011, 2012, 2015, and 2017 DMH submitted grant applications to SAMHSA and CMH to develop initiatives to integrate mental health and primary healthcare. Although none of these grant applications were successful, the opportunities for

collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities.

2. **Describe how the state 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 Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State-Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) Teams across the state.
   - As part of their application to the DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services.
   - 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

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

   Who is responsible for monitoring access to M/SUD services by the QHPs?

   The Mississippi Department of Health
4. **Is the SSA/SMHA involved in any coordinated care initiatives in the state?** ***Yes***
5. **Do the behavioral health providers screen and refer for:**
   - ***a.*** **Prevention and Wellness Education?** ***No***
   - **b. Health risks such as:**
     - **a. Heart disease?** ***No***
     - **b. Hypertension?** ***No***
     - **c. High cholesterol?** ***No***
     - **d. Diabetes?** ***No***
   - **c. Recovery Supports?** ***Yes***

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.

6. **Is the SSA/SMHA involved in the development of alternative payment methodologies including risk-based contractual relationships that advance coordination of care?** ***No***
7. **What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?**

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

Health Disparities

1. **Does the state track access or enrollment in services, types of services received, and outcomes of these services by: race, ethnicity, gender, LGBT, and age?**
    a. **Race** **Yes**
    b. **Ethnicity** **Yes**
    c. **Gender** **Yes**
    d. **Sexual Orientation** **No**
    e. **Gender Identity** **No**
    f. **and Age** **Yes**

2. **Does the state have a data driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?** ***No***
3. **Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?** ***Yes***
4. **Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provided support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for disperse populations?** ***No***
5. **If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?** ***N/A***
6. **Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care?** ***No***

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. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible. 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.

Innovation in Purchasing Decisions

1. **Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?** ***Yes***

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

Evidence-Based Practices for Early Intervention to Address Early Serious Mental Illness (ESMI)-10% Set Aside

1. **Does the state have policies for addressing ESMI?** ***Yes***
2. **Has the state implemented any evidence-based practices (EPBs) for those with ESMI?** ***Yes***

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

   The five programs operated by Region 6, Region 8, Region 9, Region 13, 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 an ESMI?** ***No***
5. **Does the state collect data specifically related to ESMI?** ***Yes***
6. **Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?** ***Yes***
7. **Please provide an updated description of the state's chosen EPBs for the 10% 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 2020 and FFY 2021 for your state's ESMI 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 five (5) programs. DMH plans to facilitate an on-site for new CSC team members as well as continue monthly technical assistance calls with the NAVIGATE consultants.
   Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10% Set Aside for ESMI.
   The state collects data quarterly from Regions 6, 8, 9, 13 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.
9. **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.

Person-Centered Planning (PCP)

1. **Does your state have policies related to person-centered planning?** ***Yes***
2. **If, no describe any action steps planned by the state in developing PCP initiatives in the future.** ***N/A***
3. **Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.**
   Consumers and caregivers are involved in making health care decisions and guiding the treatment and recovery process through Wraparound Facilitation, Peer Support Services, Wellness Action Recovery Plans and Individual Action Recovery Plans, and Personal Outcome Measure (POM) interviews. During Personal Outcome Measure (POM) interviews, individuals are asked about preferences including dreams and goals. Individuals are asked to describe their dreams and goals. In turn, providers are questioned as to how they are supporting individuals to achieve their stated dreams and goals. Regarding the 25 Quality of Life Measures, individuals are asked if they possess these qualities in their lives, and if so, are they satisfactory. The Initial Assessment utilized by all DMH certified providers has been redesigned to reflect this change.

4. **Describe the person-centered planning process in your state.**
   The Department of Mental Health is transforming Mississippi's public mental health system into one that is person-centered and recovery-oriented. The Initial Assessment and Individual Service 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 2018, 1,329 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.

Program Integrity

1. **Does the state have a specific policy and/or procedures for assuring that the federal program requirements are conveyed to intermediaries and providers? *Yes***
2. **Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? *Yes***

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 three year certification cycle to ensure that all DMH certified providers have an on-site compliance/certification visit at a minimum of twice during that certification cycle. In addition to the on-site compliance visits, the DMH regularly conducts visits to certified providers to certify additional new programs and services. The DMH does institute a CQI process as part of its monitoring. As issues of noncompliance regarding health, safety, and programmatic standards are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues and maintain ongoing compliance. Providers develop

and submit plans of compliance to the DMH for approval and subsequent implementation. In turn, the DMH conducts follow up visits to ensure that corrective action is taken and remains ongoing. The DMH tracks all deficiencies to identify trends and patterns and make changes to policy as needed

Tribes

1. **How many consultation sessions have the state conducted with federally recognized tribes?** ***None***
2. **What specific concerns were raised during the consultation session(s) noted above?** ***N/A***

The DMH Bureau of Behavioral Health Services works collaboratively with the MS Band of Choctaw Indians and continues to certify and fund prevention services with Choctaw Behavioral Health. The Department of Mental Health continues to have an individual from the Choctaw Tribe participating on the Multicultural Task Force. The Director of Choctaw Behavioral Health serves on the planning committee for the Annual Statewide Trauma Informed Care Conference. She ensures sessions are inclusive of issues relating to staff and individuals receiving services at their agency. The MS Band of Choctaw Indians has representation on the MS Mental Health Planning and Advisory Council.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service System

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

To enable individuals with mental illness to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the 14 CMHCs offer an array of services. These services include crisis services, which include Mobile Crisis Response Teams (MCeRTS), Psychosocial Rehabilitation Programs, Intensive Community Support Services, Peer Support Services, Supported Employment Services (offered by eleven (11) CMHCs), and PACT Teams (offered by eight (8) CMHCs). In addition, twelve (12) CSUs are available throughout the state to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Housing and support service needs are addressed through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

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

Physical health	***No***
Mental health	***Yes***
Rehabilitation services	***Yes***
Employment services	***Yes***
Housing services	***Yes***
Educational services	***Yes***
Substance misuse prevention and SUD treatment services	***Yes***
Medical and dental services	***No***
Support services	***Yes***
Services provided by local school systems under IDEA	***Yes***
Services for persons with co-occurring M/SUDs	***Yes***

3. Describe your state's case management services

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

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

The Mobile Crisis Response Teams (M-CeRTs) provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. The M-CeRTs target individuals experiencing a situation where the individual's behavioral health needs exceed the individual's resources to effectively handle the circumstances. Without mobile crisis intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. In FY 2018, the MCeRTs made 26,184 contacts. 18,651 of those contacts were face-to-face visits.

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. In FY 2018, 3,513 individuals were served in the CSUs with a 91% diversion rate from inpatient care.

Mississippi currently has ten (10) Programs of Assertive Community Treatment Teams (PACT). In FY 2018, the PACT Teams served 384 individuals and had 145 new admissions.

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

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

Making a Plan (MAP) Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement. In FY 2018, 55 MAP teams served 881 children and youth.

Criterion 2: Mental Health System Data Epidemiology

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	160, 265	Not required
2. Children with SED	33,345	Not required

Describe the process by which your state calculates the prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes.

Children and Youth

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 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 2017 is 370,504. Mississippi remains in the group of states with the highest poverty rate (27.7% age 5–17 in poverty, based on URS Table 1). Therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2017 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 40,755 – 48,166
- 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 25,935– 33,345

Adults

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi in 2017. URS Table 1 reports that there are 2,257,249 adults in Mississippi (ages 18 years +). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2017, ages 18 years and above, is 121,891 with a lower limit estimate of 83,518 and an upper limit estimate of 160,265.

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 both 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 FY19 – FY21 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: Children's Services

1. **Does your state integrate the following services into a comprehensive system of care?**
   - a. **Social Services** ***Yes***
   - ***b.*** **Educational Services including services provided under IDEA** ***Yes***
   - c. **Juvenile Justice Services** ***Yes***
   - ***d.*** **Substance misuse prevention and SUD treatment services** ***Yes***
   - ***e.*** **Health and mental health services** ***Yes***
   - f. **Establishes defined geographic area for provision of the services of such system** ***Yes***

Criterion 4: Targeted Services to Rural and Homeless Populations

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

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

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

Criterion 5: Management Systems

Describe your state's management system.

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.

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.

Federal Block Grant Award FY 2019	
Administration Amount	$298,682
Set Aside	$800,000
Amount to be awarded	$6,272,319
Children's portion	$2,360,006
Adult portion	$2,813,631

Quality Improvement Plan

1. Has your state modified it CQI plan from FFY 2018 – FFY 2019? ***Yes***

The Mississippi Board of Mental Health's DMH Strategic Plan is an essential tool that drives the transformation of the mental health system into one that is outcome-oriented and community-based. The Plan serves as a map for guiding the direction the DMH is taking to meet the goals and changing demands of mental health care in Mississippi. The Strategic Plan is continually streamlined with both mid-year and end-of the year reports recording progress made in achieving the goals and objectives of the Plan. The Plan is revised annually with input from consumers, advocates, stakeholders, and outcome leaders. The current DMH Strategic Plan for FY 2020 – FY 2022, as well as prior Strategic Plans, highlights, and mid and end of year reports since 2010, can be found and reviewed at http://www.dmh.ms.gov/resources/

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

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

The DMH tracks and responds to serious or critical incidents. The DMH defines serious or critical incidents as incidents which include but are not limited to suspected abuse, neglect or exploitation, injury occurring at a program location, death, suicide attempt at a program location, elopement from a program, medication errors, etc. Certified providers are responsible for reporting serious incidents to the Office of Incident Management within 24 hours. The Office of Incident Management triages all reports, assigns a category of incident, and level for DMH response/follow-up. The Office of Incident Management conducts on-site follow up on serious incidents assigned a Level III. The Office of Incident Management also utilizes a CQI approach to its follow up process. As issues are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues. Providers develop and implement corrective action to prevent future occurrence.

The Office of Consumer Support is responsible for operating the state's grievance system. Individuals may report a grievance regarding the care of someone receiving services through the public mental health system. All certified programs are responsible for posting DMH's 1-877 line in the program areas and incorporating the Office of Consumer Support into their local level grievance procedures that are shared with all people receiving services. Much like the serious incident management system, the Office of Consumer Support triages all grievances received, assigns a category of grievance and a level for DMH response/follow-up. The DMH's target for resolution of grievances is 30 days from the date filed.

Trauma

1. **Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?** ***Yes***
2. **Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?** ***Yes***
3. **Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?** ***Yes***
4. **Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?** ***Yes***

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. The 2017 Trauma Informed Care Conference was held September 27-29, 2017. These annual conferences have brought together more than 600 participants each year. The sessions are inclusive and appropriate for a diverse audience representing mental health and substance abuse professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more. The 6th Annual Trauma Informed Conference will be held September 25-27, 2019 in Jackson, Mississippi.

Criminal and Juvenile Justice

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 re-entry into the community that includes connecting with behavioral health services?** ***Yes***
2. **Does the state have a plan for working with law enforcement to deploy emerging strategies to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?** ***Yes***

3. **Does the state provide cross-trainings for behavioral health providers and criminal juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?** ***Yes***
4. **Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? Yes**

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

Program eligibility criteria includes offenders with co-occurring mental health and substance use disorders who score medium-to-high risk for recidivism and are returning to Hinds County for community supervision. Pre-release services include a full array of mental health, substance use, and trauma assessments to determine individuals' needs to inform integrated risk-based treatment and reentry plans. Post-release services are centered around a clinical intensive outpatient program that integrates a correctional curriculum developed by the National Institute of Corrections "Thinking for a Change". MDOC Probation/Parole staff delivers the "Thinking for a Change" sessions during IOP group at Hinds Behavioral. This allows offenders to complete their supervisory reporting without making a special trip to the probation/parole office. This model also creates an interdisciplinary team between HBHS and MDOC to offer full comprehensive support to offenders. In addition to IOP, program participants have access to all of the services offered at HBHS including medication management, crisis intervention, and recovery support services. Current plans are to serve 90 individuals during the three-year pilot program in order to develop a program model that can be replicated statewide with the receipt of additional federal grant funding.

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

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

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) 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 entered into a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost to the other law enforcement agencies. The DMH mailed letters, brochures and a video promoting the CIT training opportunity to all 82 sheriff's departments and to 49 of the major police departments around the state. DMH and DPS recognize officers who have completed CIT training by awarding them a certificate from the DMH and DPS signed by Ms. Diana Mikula and Commissioner Fisher, and they get 40 hours of CEs from DPS. In addition to the Lauderdale County CIT program, Region 12, Pine Belt Mental Health, has expanded CIT to Jones, Forrest and Lamar Counties. With funding from SAMHSA, Region 12 also helped initiate CITs in two additional counties, Harrison and Pike. Region IV Mental Health helped establish a CIT program in DeSoto County, with the Sheriff's Dept., Southaven PD, Horn Lake PD, Hernando PD, Olive Branch PD, Walls PD, and Baptist Memorial Hospital.

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 1,760 youth in FY18. 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, 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.

Crisis Services

The following are an array of services and supports used to address crisis response. Please indicate those that are used in your state:

1. **Crisis Prevention and Early Intervention**
    - a. **_X_ 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. **_X_ Suicide Prevention**
2. **Crisis Intervention/Stabilization**
    - a. **___ Assessment Triage (Living Room Model)**
    - b. **___ Open Dialogue**
    - c. **_X_ Crisis Residential/Respite**
    - *d.* **_X_ Crisis Intervention Team/Law Enforcement**
    - e. **_X_ Mobile Crisis Outreach**
    - f. **___ Collaboration with Hospital Emergency Departments and Urgent Care**

Systems

3. **Post Crisis/Intervention/Support**
    - a. **X** **WRAP Post –Crisis**
    - b. **X** **Peer Support/Peer Bridgers**
    - c. **X** **Follow-Up Outreach and Support**
    - d. **X** **Family –to-Family Engagement**
    - e. **X** **Connection to care coordination and follow-up clinical care for individuals in crisis**
    - f. **X** **Follow-Up Crisis Engagement with family and involved community members**
    - g. ___ **Recovery Community Coaches/Peer Recovery Coaches**
    - h. **X** **Recovery Community Organizations**

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 must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. The DMH funds eight 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state.

Additionally, DMH provides funding to the 14 CMHCs to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC's regions. The calls received by the crisis phone line are triaged for severity. Some calls can be handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team. Each CMHC region is required to provide mobile response services in every county they serve. The mobile crisis response teams (MCeRTS) must be able to respond within one hour in an urban area and within two hours in a rural area. The mobile crisis response teams are required to have a Master's level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity. Additionally, if the mobile crisis response team must respond in an area that may not be safe, the will have law enforcement accompany them. A strong working relationship with law enforcement is required through the grant funding. The mobile crisis response team will triage during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with psychiatric care available. The mobile crisis response team is also required to develop working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The "warm-handoff" model is used to facilitate services for the person in crisis with the next provider. Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter "regular" services with the CMHC or other provider. All individuals receiving services at a CMHC who have recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMHC staff and any significant others the individual wants involved. As part of the crisis response system, the CMHC's are required to

develop a multi-disciplinary assessment and planning team (MAP Team) made up of all the agencies that work with the most well-known individuals in the community. The MAP teams usually consists of mental health, health, human services, police department, sheriff's office, chancery clerk, faith based ministries, housing, etc., to develop a plan for the individuals in their community which consume the most time from all these agencies. The MAP Teams are encouraged to find an alternative to continually committing the same individuals over and over to one of the state behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff's Office to develop Crisis Intervention Teams (CIT)) across the state. The Lauderdale Sheriff's Office is a training site for officers from anywhere in the state to come for the 40-hour training required to be a CIT officer. The local CMHC is fully involved in the curriculum development and presentation. The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions.

Recovery

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***
    - **b. Required peer accreditation or certification?** ***Yes***
    - **c. Block grant funding of recovery support services?** ***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***
2. **Does the state measure the impact of your consumer and recovery community outreach activity?** ***Yes***
3. **Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.**

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

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

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

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

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

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

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.

Certified Peer Support Specialist Program

The DMH's Peer Support Specialist Program began in 2012. In FY 2018, 160 peers and family members were trained as Certified Peer Support Specialists and 42 DMH certified providers employed 230 Certified Peer Support Specialists. 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.

Community Living and the Implementation of Olmstead

1. **Does the state's Olmstead plan include:**
    a. **Housing services provided** ***Yes***
    b. **Home and community-based services** ***Yes***
    c. **Peer support services** ***Yes***
    d. **Employment services** ***Yes***

2. **Does the state have a plan to transition individuals from hospital to community settings?** ***Yes***
3. **What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**

The 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 transformation to a community-based service system. This transformation 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, 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.

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 14 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 14 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 230 active CPSSs as of the end of FY18. 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.

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. Currently, there are 11 Supported Employment programs across the state. DMH has developed a MOU with Department of Rehabilitative Services to assist with training and job placement.

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. This project will be on-going until September 2019.

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

Region 9 Hinds Behavioral Health Services opened a new drop-in center on May 15. The center provides 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 center also provides 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, Jackson, and Hinds counties with hopes to expand an additional center in Forrest County.

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.

Intensive Community Outreach Recovery Team (iCORT)

DMH is currently working with Region 2 Community Mental Health Center to pilot an Intensive Community Outreach Recovery Team (iCORT). 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. 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 four additional iCORTs. This will allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service.

Children and Adolescent Behavioral Health Services

1. **Does the state utilize a system of care approach to support:**
    a. **The recovery and resiliency of children and youth with SED?** ***Yes***
    b. **The recovery and resiliency of children and youth with SUD?** ***Yes***
2. **Does the state have and established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health issues**
    a. **Child Welfare?** ***Yes***
    b. **Juvenile Justice?** ***Yes***
    c. **Education?** ***Yes***
3. **Does the state monitor its progress and effectiveness around:**
    a. **Service utilization?** ***No***
    b. **Costs?** ***No***
    c. **Outcomes for children and youth services?** ***Yes***
4. **Does the state provide training in evidence-based practices:**
    a. **Substance misuse prevention, SUD treatment and recovery services for children/adolescents and their families?** ***Yes***
    b. **Mental health treatment and recovery services for children/adolescents and their families?** ***Yes***
5. **Does the state have plans for transitioning children and youth receiving services :**
    a. **To the adult behavioral health system?** ***Yes***
    b. **For youth in foster care?** ***Yes***

6. **Describe how the state provides 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 expands 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 who are 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 have a diagnosed serious emotional disorder (SED), co-occurring disorder (COD), or first episode of psychosis (FEP), are ages 3 -21, reside in Forrest, Jones, Lauderdale, or Marion Counties in Mississippi, and are involved with child protection services and/or juvenile justice, or are at risk for involvement.

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

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.

Suicide Prevention

1. **Have you updated your state's suicide plan in the last two years?** ***Yes***
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 Suicide Prevention Plan which was released in September 2016. 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 two Progress Reports documenting accomplishments made in FY 2017 and 2018. The Plan and Progress Reports can be viewed at http://www.dmh.ms.gov/resources/ under "Suicide Prevention". An FY 2019 Progress Report will be available in September 2019.

Over the last fiscal year, DMH and statewide partners have worked diligently to make progress with the objectives in the plan. From July 1, 2018 to May 31, 2019, there were 99 presentations made reaching 11,078 people. Information included risk and protective factors, warning signs, and referral information. These presentations included 75 of the state's suicide prevention campaign, Shatter the Silence, made to 10,547 participants. In September 2018, DMH received a Mental Health Awareness Training (MHAT) Grant from SAMHSA that has allowed DMH to provide Youth Mental Health First Aid training to educators, school resource officers, and parents/caregivers across Mississippi. As a result of this grant, DMH has trained 203 people as Mental Health First Aiders. An additional 106 people were trained outside of the MHAT grant in Mental Health First aid, 150 people were trained in Psychological First Aid, and 72 people were trained in Applied Suicide Intervention Skills Training (ASIST). 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 2019, DMH collaborated with the Mississippi Department of Public Safety (DPS) to develop a Shatter the Silence presentation that resonates with Highway Patrol Officers. The presentation garnered the support of the Commissioner of Public Safety and Highway Patrol officers and has been presented to the Highway Patrol Trooper School's 62nd class during their reunion in March and to the 63rd class during their graduation in May. Plans are in motion for Troop Leaders to be trained in Shatter the Silence to help spread the message among their Troopers, and in their communities. A version of Shatter the Silence was also developed for the Mississippi National Guard who invited DMH to participate in their Yellow Ribbon events for soldiers returning from active duty and their family members. Finally, Pinelake, a church with 5 campuses

statewide, has collaborated with DMH to develop a youth and adult faith-based version of Shatter the Silence. Campus ministers will be trained in August as train the trainers of Shatter the Silence to share the message with both youth and adult church members.

During the 2019 Legislative session, the Mississippi Legislature passed House Bill 1283, the "Mississippi School Safety Act of 2019." As part of the legislation, the Mississippi Department of Education shall 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 will be responsible for the selection of the content of the curriculum and will develop a focus group in the fall of 2019 to select the content. The results of the program shall be measured and reported, and such results shall be used in consideration of statewide implementation. Additionally, to increase understanding of mental health and suicide, the comprehensive local school district safety plans, beginning in the 2019-2020 school year, shall be required to include refresher training on mental health and suicide prevention for all school employees and personnel. DMH shall be responsible for the development and/or selection of the content of the training and will develop a focus group to select the content, and districts will report completion of the training to the Mississippi Department of Education. Finally, effective in the 2019-2020 school year, DMH shall develop a standardized MOU to be utilized by DMH certified providers and mental health facilities in providing mental health services to local school districts which will include standardized screening and referral protocols, procedures, and forms to be utilized by the local school districts. DMH will provide online training for appropriate school personnel to conduct initial behavioral health screenings of students experiencing or exhibiting behavioral stress or at risk of harming themselves or others.

3. **Have you incorporated any strategies supportive of Zero Suicide?** ***No***
4. **Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?** ***Yes.***

South Mississippi State Hospital, a Behavioral Health Program l in Purvis, MS developed a Choosing to Live suicide prevention group that involves patients who are either at risk for suicide. The group discusses reasons for living, breaks down the stigma around mental illness, and helps patients with safety planning. The group developed a "Coping Card" that is a template that identifies reasons for living, but also coping strategies that the person can take when they are in a mental health crisis. The patients share coping skill ideas with one another, and work on ways to deal with a suicidal crisis like social supports and distractions. The idea has been encouraged to be implemented at other state Behavioral Health Programs.

5. **Have you begun any targeted or statewide initiatives since the FFY 2018 - *FFY* 2019 plan was submitted?** ***Yes.*** The state's first three-year suicide prevention plan is near the end of its final year, and has goals and objectives slated for the FY 2020- FY2022 plan that will expand upon existing collaboration with the MS Department of Public Safety, MS Army National Guard, and Pinelake Church.

Support of State Partners

1. **Has your state added any new partners or partnerships since the last planning period?** ***Yes***

Has your state identified the need to develop new partnerships that you did not have in place? Yes

DMH was selected to participate in the Southeast School Mental Health Learning Community to focus on the implementation of multi-tiered systems of school mental health support with a special emphasis on integrating school mental health into state and district school safety planning. This is an opportunity for a team of leaders from each state to receive a one-day in-person training from national experts on comprehensive school mental health systems, connect with other leaders in the Southeast region that are working on school mental health, and participate in online learning sessions. Mississippi's team is comprised of two DMH staff, two Mississippi Department of Education staff, and two school district staff. To increase awareness, DMH partnered with the Mississippi Department of Education (MDE) to offer web-based suicide prevention training to all school district staff. As a result of HB 263 passed during the 2017 Legislative Session, two professional development series were selected for all certified and classified school district staff to complete during the 2017-2018 school year. DMH gathered a focus group consisting of school professionals, people affected by suicide, mental health professionals, and others to provide input on the course selection. School districts are to report implementation of the trainings to the Mississippi Department of Education. At the end of FY18, MDE reported that 60,197 school district staff has been trained in suicide prevention, with 26 districts left to report. Also, as a result of HB 263 that was passed in the 2017 Legislative, DMH was responsible for developing a model policy template for school districts. According to the law, all school districts are required to adopt a policy for suicide prevention. A template was developed through focus group participation and provided to MDE for implementation. School districts are monitored by MDE for assurance that the policy is adopted within the district. DMH is always open to and welcomes opportunities to partner with other agencies. As seen throughout the MHBG Block Grant application, DMH currently partners with the Division of Medicaid (Office of the Governor), Mississippi Department of Human Services, Mississippi Child Protection Services, Mississippi Department of Health, Mississippi Department of Education, Mississippi Department of Corrections, Disability Rights, Mississippi National Guard, Mississippi Attorney General's Office, Mississippi Board of Pharmacy, Mississippi Bureau of Narcotics, Mississippi Public Health Institute, University of Mississippi Medical Center, Mississippi Department of Public Safety, the ARC of Mississippi, Southern Christian Services for Children and Youth, Vicksburg Family Development Center, Families As Allies for Children's Mental Health, Inc., Canopy, Mental Health Association of the Gulf Coast, Gulf Coast Women's Center for Non-Violence, NAMI Mississippi, Mississippi United to End Homelessness (MUTEH), Mississippi Home Corporation, the Association of Mississippi Peer Support Specialist, the 14 CMHCs and all other DMH certified providers of mental health services. DMH also works closely with the institutions of higher learning in our state including the University of Mississippi, Mississippi State University, Jackson State University, Belhaven University, Alcorn State University, and the University of Southern Mississippi.

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

   In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care. Representatives from various State agencies participate on the Mississippi State Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health,

Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc.

The Mississippi Department of Mental Health's campaign Operation Resiliency in partnership with the National Guard 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.

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. 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. In addition, the Department of Corrections and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorder. Funded by a federal grant, this partnership between the Department of Mental Health and the Department of Corrections aims to reduce recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. It allows the two departments to improve identification of inmates with co-occurring substance use and mental health disorders, provide training to staff, integrate individualized treatment plans and track participant outcomes. The program focuses on people returning to Hinds County.

DMH is excited to partner with NAMI Mississippi and System of Care sites to bring together young people throughout our state to empower them to use their voice to ensure quality mental health care services that achieve positive and lasting mental wellness for all Mississippians. Open Up Mississippi is a youth-led, statewide advocacy council with the mission to engage youth and young adults as they break down barriers to gain mental wellness and utilize their strengths against the stigma of mental health. By using their voices, the goal is to seek to remove the stigma and stereotypes that prevent people from seeking mental health services.

Programs that provide services for children with mental health needs are available and accessible in the regular education setting as well as the special education arena. In Mississippi, there are fourteen (14) Community Mental Health Centers (CMHC), with each location being responsible for provision of services to local school districts certified by the Mississippi Department of Education via interagency agreements. All 14 CMHCs are required to have interagency agreements with each local school district in their region. As a result of this agreement, over 20,000 students with emotional, behavioral, or mental health challenges received mental health services in the schools in FY 2018. Statewide initiatives such as those on suicide prevention, bullying, and cybercrimes (sexting) have also played a large role in providing assistance to all students to prevent inpatient stays and residential institutionalization. In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health

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

Recently, a federal grant from the Substance Abuse and Mental Health Services Administration awarded 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 will provide training in Mental Health First Aid for Youth to educators and parents.

Students Ruled EmD under the Individuals with Disabilities Education Act of (2004)
IDEA 2004 defines emotional disturbance as a condition in which a child exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: inability to learn that cannot be explained by intellectual, sensory or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behavior or feelings under normal circumstances; general pervasive mood of unhappiness or depression; and/or tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia and does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance. The Division of Parent Outreach within the Mississippi Department of Education, Office of Special Education (OSE), provides information and training in areas of identified need to parents, students, and community organizations. This division works to build collaborative relationships with parents and organizations interested in services to children with disabilities. This division also provides the following: training regarding parental rights and services under IDEA 2004; development and distribution of materials for parents; handling of parent complaints, mediation, Resolution Sessions, and due process hearings; and conducting meetings with stakeholders. The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling. Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses counseling,

psychological services and the needs assessment. One of the eight components of the Center for Disease Control and Prevention's (CDC) coordinated school health is counseling and psychological services. In accordance with this component, Mississippi public schools are required to establish a local school wellness policy.

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. Staff attends the Mississippi United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings. In 2015, the Mississippi Home Corporation received funding from the Mississippi Legislature to partner with DMH to develop an integrated permanent supported housing project. This will ensure people with a serious mental illness who are housed as a result of permanent 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. This program began implementation in March 2016 known as CHOICE, Creative Housing Options in Communities for Everyone.

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; with plans to add an additional house for four more females in the near future. Region 9 began a Community Transition Home in May for four males in 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.

"Bridging the Gap" started at South Mississippi State Hospital (SMSH) as a series of quarterly meetings that included outpatient providers and other service agencies in the 15-county SMSH catchment area, where the hospital provides services. The hospital invited legislators, chanceries, and local law enforcement to participate so everyone could get a better knowledge base about mental health services available in the community. The program grew quickly and has evolved into a quarterly resource sharing session that provides an important communication tool for SMSH staff and community service providers as they locate resources and services for people as they are discharged from the hospital. In 2018, the program was replicated at North Mississippi State Hospital in Tupelo, East Mississippi State Hospital in Meridian, and Mississippi State Hospital in Rankin County. The meetings help ensure continuity of care for adults transitioning from the hospitals back into the community. Community Mental Health Center staff and hospital staff get to discuss patient care directly, including conversations about medication efficacy, new service programs, and how clients sustain recovery in the community

State Behavioral Health Planning/Advisory Council and Input on the Mental Health Block Grant Application

1. **How was the Council involved in the development and review of the state plan and report? (Attach meeting minutes, letter of support, etc.)**
    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.

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

b. Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns and activities into its work?

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

2. **Is the membership representative of the service population? (e.g. ethnic, cultural linguistic, rural, suburban, urban, older adults, families of young children)**
The Planning Council continues to be expanded to include representatives of all populations. Several senior and aging adults, a representative from the VA Medical Center, and a representative from the Mississippi Band of Choctaw Indians serve on the Council. Efforts to include transition-age youth are ongoing. A major barrier is the inability of young adults to attend due to conflicts with work and school schedules. Efforts are also ongoing to encourage a member of the LGBT community and a Hispanic individual to participate on the Council.

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 2020-2021 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. In 2019, the Planning Council met: February 7, 2019, May 2, 2019, and August 1, 2019. The next meeting is scheduled for November 7, 2019. At each meeting, the Council is consistently informed of the status of the Department of Mental Health's budget.

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

The Council received reports on the major initiatives planned for FY 2020-2021 at the August meeting. The State Plan Draft was presented to the Council at the August meeting. The public comment period is planned for August 12, 2019, through August 30, 2019. The Council also has the opportunity for review of the FY 2020-2021 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 14 regional community mental health centers across the state, the East MS State Hospital in Meridian, the MS State Hospital in Whitfield, the North MS State Hospital in Tupelo, the South MS State Hospital in Purvis, the Central MS Residential Center in Newton, the five regional centers for persons with intellectual developmental disabilities, the Specialized Treatment Facility and the Mississippi Adolescent Center operated by the Department of Mental Health and on the MS Department of Mental Health's website. A Draft Plan was sent directly to the directors of the community mental health centers and the Department of Mental Health facilities asking them to make the Plan available to their employees and other interested individuals in their area of the state. The Draft Plan 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
MS Department of Rehabilitation Services
MS Institutions of Higher Learning
Office of the Governor, Division of Medicaid
Mississippi Development Authority
Department of Psychiatry and Human Behavior, University of MS Medical Center
MS Primary Health Care Association
Melody Worsham, Certified Peer Support Specialist

Although some non-service representatives on the Planning Council are also members of NAMI chapters, Mental Health Associations and/or Families As Allies for Children's Mental Health, Inc., additional copies of the Draft Plan and requests for comment 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 is members of the Council.

The MS Department of Mental Health Community Mental Health Services FY 2020-2021 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission.