Project	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	Total	Recurring after December 2026
988	$3,000,000	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$10,000,000	$2,000,000
Mobile Crisis Teams	$1,400,000	$1,400,000	$1,400,000	$1,400,000	$700,000	$6,300,000	$1,400,000
Crisis Services SMI	$6,500,000	$6,500,000	$6,500,000	$6,500,000	$3,250,000	$29,250,000	$6,500,000
Mental Health First Aid for Public Safety Training	$42,000				$0	$42,000	
CIT for Law Enforcement	$300,000	$300,000	$300,000	$300,000	$150,000	$1,350,000	
Behavioral Health Crisis Services	**$11,242,000**	**$10,200,000**	**$10,200,000**	**$10,200,000**	**$5,100,000**	**$46,942,000**	**$9,900,000**
Peer Support Services	$1,500,000	$1,500,000	$1,500,000	$1,500,000	$750,000	$6,750,000	$1,500,000
Court/Law Enforcement/Hospital Liaisons	$1,080,000	$1,080,000	$1,080,000	$1,080,000	$540,000	$4,860,000	$1,080,000
Intensive Community Support Specialists	$315,000	$315,000	$315,000	$315,000	$157,500	$1,417,500	$315,000
Adolescent Offender Program	$2,600,000	$2,600,000	$2,600,000	$2,600,000	$1,300,000	$11,700,000	$2,600,000
Behavioral Health Diversion	**$5,495,000**	**$5,495,000**	**$5,495,000**	**$5,495,000**	**$2,747,500**	**$24,727,500**	**$5,495,000**
IDD Crisis Services & Supports	**$3,200,000**	**$3,200,000**	**$3,200,000**	**$3,200,000**	**$1,600,000**	**$14,400,000**	**$3,200,000**
TOTAL	**$19,937,000**	**$18,895,000**	**$18,895,000**	**$18,895,000**	**$9,447,500**	**$86,069,500**	**$18,595,000**

Mississippi Department of Mental Health (MDMH) Proposal for State ARPA COVID Funding

Goal: To meet the needs of Mississippians with behavioral health (mental health and addiction services) and intellectual and developmental disabilities following the COVID-19 pandemic by increasing the utilization of community-based services for behavioral health and intellectual and developmental disabilities.

Overview: The impact of COVID-19 on the mental health of Mississippians cannot be overstated among all demographics with the number of people reporting symptoms of anxiety, depression and suicidal ideation increasing. The number of crisis situations in mental health, addiction, and intellectual and developmental disabilities are continuing to increase. Under normal circumstances, MS faces formidable mental health (MH) adversities and co-occurring disorder (COD) problems. The COVID-19 pandemic, coupled with social distancing directives, shelter-in-place orders, and mass unemployment, has raised these threats to critical levels in the nation's poorest state.

Over the last six years, MDMH has been strategically expanding community-based mental health services in Mississippi. These efforts have included the development of Mobile Crisis Response Teams statewide, expansion of crisis stabilization unit (CSU) beds, availability of intensive community support services in all 82 counties, and a comprehensive effort to transform the system to a recovery-oriented system of care. While this has helped place Mississippi in a better position to respond to the needs during and following the pandemic, Mississippi can continue to address gaps and needs and increase access to services through the services/supports in this proposal. These funds will be utilized to expand crisis services (behavioral health and IDD), diversion efforts, state hospital admission reduction efforts, implementation of 988, evidence-based training needs, and address workforce issues.

Behavioral Health Crisis Services

- **988 Implementation:** Funding is requested for the implementation of 988. The National Suicide Hotline Designation Act, HR 4194, was signed by the president in October 2020 and directed the FCC to designate a three-digit telephone number, 988, as a national, universal number for the purpose of national suicide prevention and a mental health crisis hotline system operating through the National Suicide Prevention Lifeline. The 988 number will go live by July 16, 2022 nationwide – including Mississippi.

  Mississippi is in the process of developing our state's roadmap for how we will address key coordination, capacity, funding, and communication strategies foundational to the launching of 988. We meet monthly with stakeholders and a planning consultant to

work on our state’s plan. In Mississippi, we currently have two Lifeline Centers – CONTACT the Crisis Line in Jackson and CONTACT Helpline in Columbus. According to Lifeline data, Mississippi received 14,750 calls to the Lifeline in 2020 and the Lifeline call volume in MS has increased 77% since 2016. The Mississippi Lifeline Centers had a 90% in-state answer rate for the period of 7/1/2020 to 9/30/2020 and an 86% in-state answer rate for the 2020 year. The Lifeline centers are staffed by full-time and part-time staff, as well as a host of volunteers.

DMH is working on call and cost projections to determine how many additional staff may be needed in the future to handle the projected increased call volume due to having an easy-to-remember three-digit number. Vibrant, the administrator of the Lifeline, produced state volume and workload estimates, but we are working through our own projections for the state as well. Vibrant predicts that the nation will see a growth of 6 million additional calls in year one using a low volume model with a 12 million call growth if using a high-volume model. The most difficult part of our planning process is trying to associate a cost for the increased growth due to not knowing the data until the new number is implemented.

The National Suicide Hotline Designation Act included language allowing each state to pass their own legislation funding 988 the same way as 911, through state-managed monthly customer service fees. The federal law allows for the revenue generated by these fees to go toward funding local crisis centers and supporting the development and implementation of wraparound crisis care services.

The State is estimating approximately $4 million for first-year implementation for costs related to technology, dispatch system, and staffing. DMH has received $1,000,000 in federal funds for this purpose and is requesting $3,000,000 for the remaining implementation and $2 million for the subsequent years.

DMH projects an increase of 25,578 initial calls to the Lifeline centers; 6,250 follow-up calls; and 2,127 additional text and chat connections using a low growth model during the first year of implementation. As 988 becomes widely publicized, usage is expected to increase over the next few years. Mississippi predicts the need for crisis services throughout the state will also increase as 988 becomes more well-known and used. Until data is collected after the first year(s) of implementation, the year after year cost is unknown; however, growth is expected the first five years after implementation. **Approximately $3,000,000 start-up costs and $2,000,000 continued operation cost each year.**

- **<u>Mobile Crisis Response Teams</u> -** In 2014, each of the Community Mental Health Centers (CMHCs) developed Mobile Crisis Response Teams (MCeRT) to provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the 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. In Fiscal Year 2021, there were a total of 34,483 contacts; a total of 11,937 face-to-face responses; and 3,087 responses handled in conjunction with law enforcement. It is anticipated that an increase in the need for and referrals to Mobile Crisis Response Teams will result from the implementation of 988. DMH is requesting an additional $100,000 per Mobile Crisis Response Team to aid in the anticipated increased need. **<u>Approximately - $1,400,000 per year.</u>**

- **<u>Crisis Services SMI:</u>** Over the last three years, Mississippi has expanded access to Crisis Stabilization Units. In FY19, the shift in funds from DMH's inpatient programs to the Service Budget allowed for the opening of 44 additional crisis stabilization beds. Previously, Mississippi had eight, 16-bed Crisis Stabilization Units across the state. There are now 13 Crisis Stabilization Units and 176 beds. Additional funding will be utilized to expand capacity to include approximately 60 more beds in the state. The beds offer time-limited residential treatment services to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient treatment. In FY21, the CSUs had an 89% diversion rate from people having to enter the state hospitals for inpatient treatment and served 3,022 Mississippians. **<u>Approximately $6,500,000 per year.</u>**

Crisis Stabilization Bed Expansion			
Region 3	Add 8 beds (16 total)	$650,000.00	
Region 7	Add 4 Beds (12 total)	$400,000.00	
Region 8	Add 16 Beds	$1,450,000.00	
Region 9	Add 16 Beds	$1,450,000.00	
Region 12	Add 8 Beds/Diversion Center	$1,900,000.00	Hybrid Model

Region 14	Add 8 Beds (16 Total)	$650,000.00	
Total	**60 beds**	**$6,500,000.00**	

- **Mental Health First Aid for Public Safety Training –** The National Council for Mental Wellness is the proprietor of Mental Health First Aid (MHFA), evidence-based mental health awareness courses that teach participants how to recognize that a person may be developing a mental health or substance use problem or is in crisis. It teaches participants the skills needed to reach out and provide initial support and connect the person to the appropriate care. The 8-hour course is taught through a five-step action plan that includes:
    - Accessing for risk of suicide or harm.
    - Listening non-judgmentally
    - Giving reassurance and information
    - Encouraging appropriate professional help
    - Encouraging self-help and other support strategies

  The **Public Safety** designation is a supplement to the Adult MHFA training. It is intended for law enforcement, probation, parole, and corrections officers as well as 911 dispatchers and focuses on the unique experiences and needs of public safety personnel. It is a valuable resource that can make a difference in their lives, their co-workers' and families' lives, and the communities that they serve. The Public Safety designation is best received in an officer-to-officer format. The National Council for Mental Wellness offers training for individuals to become MHFA Instructors. DMH proposes Mississippi to host a train-the-trainer (approximately $36,000 for 16 trainers) and then provide MHFA Public Safety Training for approximately 300 people in the first 12 months (approximately $6,000). **Approximately $42,000 for one year.**

- **Crisis Intervention Training for Law Enforcement -** Crisis Intervention Training (CIT) is a pre-booking jail diversion program designed to improve the outcomes of police interactions with people with mental illnesses. CIT enhances communication, identifies mental health resources for assisting people in crisis and ensures that officers get the training and support they need. CIT programs provide officers with 40 hours of intensive training, including:
    - **Learning from mental health professionals and experienced officers in the community.** One of the reasons CIT is successful is that it connects officers with a team of clinicians and fellow officers who can advise, problem-solve and support them when a challenging situation occurs.
    - **Verbal de-escalation skills.** CIT teaches a new set of skills for ensuring officer safety – the words, approach and body language that convince a person to get help, or defuse a potentially violent encounter.

- **Scenario-based training on responding to crises.** With the help of volunteers or actors, officers practice their skills in common crisis situations, and get immediate feedback from instructors and classmates.

Mississippi currently has 8 fully operational CIT Programs. There are many more communities that would love to have a CIT program, but without funding dedicated solely to CIT development, Community Mental Health Centers and law enforcement agencies do not have enough human resources to devote the needed time to establish the programs.

Due to the number of courses and training modules in a 40-hour curriculum, CIT training is costly. Mental health experts give approximately 18-20 hours of lectures on a wide array of mental health issues. There are 11-12 hours of de-escalation instruction and role play that must be conducted by trainers certified by the University of Memphis CIT Center. The role of coordinating one of these 40-hour trainings and all the details associated is very time consuming.

With this funding, DMH can fund four staff dedicated to CIT expansion throughout the state and contract with off duty CIT officers to help conduct the training. These trainers will go to communities that want CIT and will train a local group of law enforcement officers in CIT while the clinical staff of the local CMHC observe. Technical assistance can be provided to the interested community as much as needed. Then they can return to that community and conduct a train-the-trainer training with the newly trained CIT officers and the CMHC staff that observed the initial course. This team could help start three new fully operational CIT programs a year. **Approximately - $300,000 per year.**

Behavioral Health Diversion

- **Peer Support Services:** CPSSs have been included on Mobile Crisis Response Teams, PACT Teams, Supported Employment pilot sites, and other areas throughout the public mental health system. These individuals use their lived experiences in combination with skills training to support peers and/ or family members with similar experiences. CPSSs are employed at all DMH operated behavioral health programs for adults. DMH will utilize funding to expand the availability of peer support services to begin three pilot peer respite programs. A peer respite is a voluntary, short-term, day program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates during the day in a homelike environment. Peer respites were designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a psychiatric crisis. The premise behind peer respites is that psychiatric emergency services can be avoided if less coercive or intrusive supports are available in the community. **Approximately $1,500,000 per year.**

- **Court/Law Enforcement/Hospital Liaisons:** DMH will work with community providers to pilot court/law enforcement/hospital liaison programs to connect people with community-based services to decrease the number of commitments to inpatient acute psychiatric services. These specialist services aim to intervene early in the commitment process by working with the individual and/or loved ones who are seeking a commitment or at risk for institutionalization and linking with treatment. The liaisons will work directly to ensure people receive appropriate evaluations and needed mental health services. The liaison is responsible for facilitating communication and collaboration between judicial, law enforcement and behavioral health systems. Liaisons 1) promote positive outcomes for individuals living with mental health or co-occurring behavioral health conditions; 2) keep judges, district attorneys, law enforcement, and defense attorneys informed about available community-based behavioral health services for defendants; and 3) connect individuals to behavioral health services, including conducting and/or referring for screenings and evaluations to divert from institutionalization. DMH recommends the pilot program for up to 18 liaisons in Community Mental Health Centers for counties based on commitment data. DMH is already funding this in four Community Mental Health Center regions in FY22. **Approximately $1,080,000 per year.**

- **Intensive Community Support Specialists for Children and Youth:** With federal funding, DMH is currently adding six Intensive Community Support Specialists for children and adolescents at Community Mental Health Centers. Intensive Community Support is a service that promotes independence and quality of life through the coordination of appropriate services and the provision of constant and on-going support as needed by the child or youth and their family. The Intensive Community Support Specialist will coordinate required services from across the mental health system as well as other systems such as the local school, Child Protection Services, Youth Court, crisis response, and or/ substance use services to reduce recidivism of children and youth being placed in inpatient psychiatric care. The Intensive Community Support Specialist is the primary contact for inpatient facilities discharging children and youth back into the community and works closely with the facilities to develop and coordinate aftercare plans to promote successful transitions from the facilities to the services and resources in the communities. DMH would like to expand this further to the remaining seven CMHCs that do not have an ICSS to have this service available in all CMHCs. **Approximately $315,000 per year.**

- **Adolescent Offender Program -** Traditionally, the mental health component of Adolescent Offender Programs (AOPs) has been implemented utilizing a day treatment model. With AOPs in operation, youth court judges and referees have an alternative to court-ordering youth who have mental health needs to lengthened stays in juvenile

detention centers or other consequences that may lack a mental health component. Youth appropriate for participation in AOPs are youth ages 12 to 18 who have committed non-violent crimes, misdemeanors or status offenses such as curfew violations or truancy and who have or who are suspected of having a mental health diagnosis and/or substance use disorder. Youth participating in AOPs receive individual therapy, family therapy, and Community Support Services. An evidence-based curriculum for juvenile offenders, such as SPARCS (Structured Psychotherapy for Adolescents Responding to Stress), is utilized to teach coping skills for substance use, anger, depression, anxiety and related issues in a supportive group setting. Each program operates with at least four but no more than 10 youth in the program. A licensed or DMH credentialed master's level therapist is required for each program in addition to an assistant with at least a high school diploma or GED. The program operates at least two days per week for two hours each day up to five days a week for five hours a day. Length of the program is determined at the discretion of the judge and/or when identified goals in the Individual Service Plan are achieved. Typically, length of stay for youth in the program is three to nine months. DMH recommends adding one program in each of the 13 Community Mental Health Centers. **Approximately $2,600,000 per year**.

Behavioral Health Treatment

- **Behavioral Health Treatment Services for Adults and Children and Youth:** DMH is requesting to provide discretionary funding to each of the 13 CMHCs for mental health and substance use treatment, for individuals who have little to no ability to pay, to access services, or community linkage. This would include adults with serious mental illness and children and youth with a serious emotional disturbance that results in functional impairment which substantially interferes with, or limits one or more major life activities. According to the Community Mental Health Centers, their indigent care for 2020 was roughly 31 million. **Approximately $10,000,000 per year.**

- **Medication Assistance Fund:** DMH will increase the Medication Assistance Fund to be used to provide medication access to people in the community who have a SMI and who are receiving services through a CMHC who could not otherwise access prescribed medication that they need to avoid a serious risk of hospitalization. The fund can be accessed for a person once the CMHC has provided documentation that the CMHC has: 1) assisted the person in initiating the enrollment process for Medicaid, and/or 2) submitted a request to enroll the person in a prescription assistance program. Persons will be eligible for medication assistance for a period of 90 days. The 90-day eligibility period may be renewed, for up to one year, upon a showing by the requesting CMHC that attempts to secure alternative medication access are ongoing and have not yet been successful. **Approximately $400,000 per year.**

Certified Community Behavioral Health Clinics

- **Certified Community Behavioral Health Clinics (CCBHC) -** The Certified Community Behavioral Health Clinic model is designed to increase access to and improve the quality of a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs must directly provide nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care. In 2018, eight states participated in a Medicaid demonstration program and in 2020 Congress expanded the original program to include additional states. The CCBHC demonstration states have lowered costs, improved outcomes, contributed to building critical mental health and substance use care system capacity and infrastructure to meet rising levels of need, and integrated services with the rest of the health care system. State officials credit the CCBHC prospective payment system as instrumental to the success of their CCBHC programs.
    - States reported decreased reductions in emergency department and hospital visits among CCBHC clients, leading to cost offsets.
    - The CCBHC demonstration helped states mitigate the effects of the mental health and substance use service workforce shortage by enabling clinics to hire and retain vital staff.
    - Rates of initiation, engagement and follow-up for mental health and substance use care tended to improve under the CCBHC demonstration program, with CCBHCs reporting higher performance than non-CCBHCs on key metrics.
    - Increased access to comprehensive, evidence-based services to curb the opioid crisis, including MAT.

  Mississippi currently has three Community Mental Health Centers that that have received a two-year SAMHSA CCBHC expansion grant, Singing River Services, Communicare, and Southwest MS Mental Health Complex. Community Mental Health Centers around the state are interested in implementing the CCBHC model, but one-time start-up costs are needed for technical assistance, implementation and expansion of required services, staff training, possible new technology to leverage telehealth, hiring of key employees, meeting access to care and organizational governance requirements. **DMH supports the Mental Health Coordinator's request for funds.**

IDD Crisis Services & Supports

- **Crisis Services IDD:** DMH remains committed to strengthening the safety net of people with intellectual and developmental disabilities (IDD). This proposal includes adding one six-bed, and four four-bed Crisis Diversion Homes for adults with IDD. This will provide timely access to essential services and supports necessary for persons with developmental disabilities to maintain health and safety and to address behavioral, psychiatric, medical, or other needs, when other services and supports fail, are interrupted, are not available, or additional services and supports are necessary for an urgent crisis need. The program is for a person who is in crisis or at risk of being in crisis. Many times, this crisis is because the person has exhausted his/her current living arrangements and have nowhere to live. This home will allow people to be diverted from institutional placement. The homes are staffed 24/7 and the persons admitted to the program will participate in a Person-Centered Plan. Referrals are received statewide. Referrals may come from DMH, private providers, and family/friends of individuals in crisis. Those that qualify for waiver are typically enrolled into the waiver program via a crisis capacity waiver slot. These individuals are then sent home with services to prevent a future crisis, or are admitted into a Supervised, Supported, or Shared-Supported community program. If a person in the Crisis Diversion Home is deemed not appropriate for waiver services upon completion of diagnostic testing, then alternate placement is sought.

  This also includes working with the Center for START Services, University of New Hampshire Institute on Disability UCED to provide consultation and training to DMH for the purpose of strengthening the services and supports for children and adults with Intellectual and Developmental Disabilities and co-occurring mental health needs. A training and consultation plan will be provided by the Center for START Services, University of New Hampshire Institute on Disability UCED that includes a three-year plan for consultation and technical support in the design and implementation of a pilot program for individuals with IDD and mental health service needs and training to develop the expertise needed to provide effective crisis supports to people with intellectual/developmental disability and mental health needs. **Approximately $3,200,000 per year.**

Workforce Development

- **Workforce Educational Leave** – DMH’s state operated programs are experiencing increased turnover in critical positions compounded by recruitment difficulties, especially in positions that serve in the front-line capacity of providing care. These positions have always been the most difficult to recruit and retain due to the low existing start salaries and the type of work required. The pandemic has created an even

larger gap in the availability of applicants complicated by the salary range for the jobs. DMH recently implemented a 20% recruitment flexibility for current and newly hired direct care employees and temporarily increased Type Duty Location pay for nurses to provide staffing relief and aid in the retention of these critical positions. As the state and nation continue to compete for healthcare workers, DMH is requesting COVID funds to provide paid educational leave for nursing students at DMH state operated programs. Paid educational leave is a valuable benefit to both the employee and employer, reducing turnover among staff interested in advancing their career paths by investing in their professional and educational growth, and attracting job seekers. DMH is requesting funds to enter educational leave agreements with up to 30 nursing students every other year for a total of 60. **Approximately $405,000 per year.**

- **Retention of Critical Employees –** DMH's state operated programs are struggling to recover from staff shortages experienced during the pandemic. Programs have experienced increased turnover in critical positions compounded by recruitment difficulties due to the type of work required, non-competitive wages, and a lack of qualified applicants. The number of filled positions continued to decrease over the past year with 5,701 DMH employees reported on October 31, 2020, compared to 5,130 DMH employees reported on October 31, 2021. DMH filled positions have steadily decreased since the start of the pandemic although the need for mental health, IDD, and substance use services has remained constant. In addition to the front-line staff providing direct care to the individuals we serve, agencies have experienced significant staffing challenges in non-administrative positions. DMH is requesting a 10% premium pay for employees in classifications such as maintenance and warehouse, social work, recreation therapy, behavioral health (psychology), housekeeping, laundry, food service, direct care, nursing, speech therapy, occupational and physical therapy, pharmacy, teachers, and vocational training instructors. These employees have worked short-staffed throughout the pandemic and have been required to work additional shifts with some having to cover direct patient care in addition to their professional duties. DMH is requesting the funding to provide a 10% increase for the employees in these classifications based on the new Project SEC2 compensation plan to aid in retention. **Approximately $9,200,000 per year.**