

**MISSISSIPPI DEPARTMENT
OF MENTAL HEALTH
BEHAVIORAL HEALTH
SERVICES**

FY 2024-2025

STATE PLAN



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: Wendy
Last Name: Bailey
Agency Name: Mississippi Department of Mental Health
Mailing Address: 239 North Lamar Street, 1101 Robert E. Lee Building
City: Jackson
Zip Code: 39201
Telephone: 601-359-1288
Fax: 601-359-6295
Email Address: wendy.bailey@dmh.ms.gov

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

From: 7/1/2022
To: 6/30/2023

IV. Date Submitted

Submission Date: 9/1/2023

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

State Information

State Information

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

Fiscal Year 2024

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services
Administration
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
Title 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 Grant 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
Section 1920	Early Serious Mental Illness	42 U.S.C. 300x-9
Section 1920	Crisis Services	42 U.S.C. 300x-9
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 19 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, as applicable, with 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 Coastal 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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> [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 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

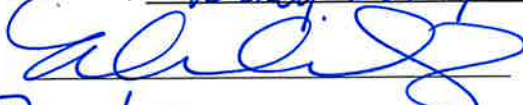
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and

summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: Wendy Bailey

Signature of CEO or Designee¹: 

Title: Executive Director

Date Signed: 8/8/23
mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024". The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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 Mississippi Department of Mental Health. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. Per 41-4-3 There is created a State Board of Mental Health, referred to in this chapter as "board," consisting of nine (9) members, to be appointed by the Governor, with the advice and consent of the Senate, each of whom shall be a qualified elector. One (1) member shall be appointed from each congressional district as presently constituted; and four (4) members shall be appointed from the state at large, one (1) of whom shall be a licensed medical doctor who is a psychiatrist, one (1) of whom shall hold a Ph.D. degree and be a licensed clinical psychologist, one (1) of whom shall be a licensed medical doctor, and one (1) of whom shall be a social worker with experience in the mental health field.

No more than two (2) members of the board shall be appointed from any one (1) congressional district as presently constituted.

Each member of the initial board shall serve for a term of years represented by the number of his congressional district; two (2) state at large members shall serve for a term of six (6) years; two (2) state at large members shall serve for a term of seven (7) years; subsequent appointments shall be for seven-year terms and the Governor shall fill any vacancy for the unexpired term. The board shall elect a chairman whose term of office shall be one (1) year and until his successor shall be elected.

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

The Deputy Executive Director of Behavioral Health Services administers and monitors the delivery of community and state operated behavioral health services. The Deputy Executive Director of Behavioral Health Services supervises the Chief Clinical Officer of Behavioral Health Services, and the Bureau of Certification and Quality Outcomes within the Central Office. The Deputy Executive Director of IDD Services oversees the community and state operated services for intellectual and developmental disabilities and supervises the Chief Clinical Officer of IDD Services.

The Bureau of Behavioral Health Services is under the direction of the Chief Clinical Officer and is responsible for planning, development, and supervision of an array of services and supports for children/youth and adults in the state with serious emotional disturbance, serious mental illness, and



substance use disorders. The Bureau is comprised of two main areas, Community Mental Health Services and Alcohol and Drug Addiction Treatment and Prevention 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 certified community service providers.

Community Intellectual and Developmental Disabilities is under the direction of the Chief Clinical Officer of Community IDD Services and is responsible for planning, development, and supervision of an array of community services for people in the state with intellectual and developmental disabilities which includes the ID/DD Waiver Program and the IDD Community Support Program. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by Community Mental Health Centers and other community service providers.

The Bureau of Certification and Quality Outcomes is responsible for maintaining the safe provision of high-quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes two divisions, The Division of Certification, and the Office of Utilization Review.

The Deputy Executive Director of IDD Services oversees the agency's state operated IDD programs. The Deputy Executive Director is responsible for planning, development, and supervision of an array of services for people in the state with intellectual and developmental disabilities. The Department also operates regional programs for persons with intellectual and developmental disabilities and a specialized program for adolescents with intellectual and developmental disabilities.

The Deputy Executive Director of Behavioral Health Services is responsible for oversight of community and state operated behavioral health services. The Department administers and operates state behavioral health programs and a specialized behavioral health program for youth. These programs serve designated counties or service areas and offer community living and/or community services.

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

Functions of the Mississippi Department of Mental Health

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational

Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

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

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

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

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

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



Regional Community Mental Health Centers (CMHCs): The CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 11 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 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Melody Madaris, Ph.D. Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	LIFECORE Health Group Raquel Rosamond, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595

<p>Region 4: Alcorn, DeSoto, Prentiss, Tippah, Tishomingo</p>	<p>Region IV Mental Health Services Jason Ramey, Executive Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883</p>
<p>Region 6: Attala, Bolivar, Carroll, Coahoma, Grenada, Holmes, Humphreys, Issaquena, Leflore, Montgomery, Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, Washington Washington</p>	<p>Life Help Phaedre Cole, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211</p>
<p>Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston</p>	<p>Community Counseling Services Ray Evins, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347</p>
<p>Region 8: Copiah, Madison, Rankin, Simpson, Lincoln</p>	<p>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.)</p>
<p>Region 9: Hinds</p>	<p>Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director 3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400</p>
<p>Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith</p>	<p>Weems Community Mental Health Center Russ Andreacchio, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821</p>
<p>Region 12: Amite, Covington, Forrest, Franklin, Greene, Hancock, Harrison, Jefferson Davis, Jones, Lamar, Lawrence, Marion, Pearl River, Perry, Pike, Stone, Walthall, Wayne,</p>	<p>Pine Belt Mental Healthcare Resources Mona Gauthier, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641</p>
<p>Region 14: George, Jackson</p>	<p>Singing River Services Beth Fenech, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690</p>

Region 15: Adam, Claiborne, Jefferson, Warren, Wilkinson, Yazoo	Warren-Yazoo Behavioral Health, Inc. Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031
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Strengths and Needs of the Service System

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

- Mississippi was selected, along with eight other states, to participate in SAMHSA’s Supported Employment for Transition Aged Youth Policy Academy (SE-TAY) in June 2023. Mississippi’s eight-member team consists of representatives from Mississippi’s Department of Human Services, Department of Child Protection Services, Department of Vocational Rehabilitation Services, Department of Employment Security, Department of Education, Department of Mental Health, NAMI Mississippi, and a Certified Peer Support Specialist. An initial SE-TAY team meeting was held in July of 2023 to begin creating policies that will provide the supports and services necessary to help our youth with mental health challenges become competitively employed and/or complete educational goals. Team meetings will occur monthly, along with four (4) sponsored virtual sessions lead by SAMHSA, to develop a state-wide strategic plan to create and expand the service system to meet the competitive employment needs of Mississippi’s transition age youth with mental illness through supportive employment._

- The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances and complex needs that usually require the intervention of multiple state agencies. On the local level, the DMH provides flexible funding to 55 local interagency Making a Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Child Protection Services (CPS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services.

- The DMH and the Division of Children’s Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training staff from other child and family support service agencies. Collaborative training initiatives include Wraparound Facilitation and System of Care by the Mississippi Wraparound Institute (MWI); 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), and training MRSS for the Mobile Crisis Emergency Response Teams to provide strategies for team members to effectively deescalate, stabilize, and improve treatment outcomes for our children and youth in crisis.

- The DMH continues to fund nine CMHCs for 14 Juvenile Outreach Programs (JOP) to provide mental health services in the local detention centers and for youth with juvenile justice contact. 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. DMH funds a Youth Mental Health Court Program operated by a local CMHC to provide an array of services to youth entering the juvenile justice system to deter future justice involvement.

- Through Legislative ARPA money, funds are being provided in FY24 to the 11 CMHCs to operate Adolescent Offender Programs (AOP). Adolescent Offender Programs provide services to youth via a day treatment model that includes an evidence-based, treatment-oriented approach emphasizing family engagement and addressing the mental health challenges and/or substance use experienced by youth involved in the juvenile justice system. In addition to day treatment and through a collaborative partnership with local youth courts making referrals, adolescents and families are offered a full range of services and supports for youth with serious emotional disorders and/or serious mental illness that can include physician/psychiatric services, individual and family therapy, community support services, and peer support services.

- 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 two nationally certified Wraparound Coaches to train, implement and expand high fidelity Wraparound Facilitation across the state. Currently, eleven mental health providers are certified by DMH to support the process of Wraparound Facilitation to over 1,500 children/youth, annually.

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

- NAVIGATE is an evidence-based program designed to assist youth and young adults who have experienced their first episode of psychosis. DMH added four (4) additional NAVIGATE teams for a total of eight (8) teams located throughout the state. The NAVIGATE teams use the NIMH recommended model of Coordinated Specialty Care Teams for First Episode Psychosis (FEP). The teams continue to receive ongoing training and technical assistance from the NAVIGATE consultants.

- The Interagency Coordinating Council for Children and Youth (ICCCY) was initially developed by HB1529 and is a state level council designated to coordinate the System of Care. ICCCY resumed meeting in FY21. Membership consists of the Executive Directors from the child-serving state agencies, Families As Allies, the Attorney General, a family member of a child or youth and a youth or young adult, a local MAP team coordinator, a child psychiatrist, designated by the Mississippi Psychiatric Association, an individual with expertise in early childhood education, a representative from an advocacy organization, and a faculty member or dean from a Mississippi university that trains professionals who work in the Mississippi Statewide System of Care. The Interagency System of Care Council (ISCC) is created to serve as the state management team for the ICCCY, with the responsibility of collecting and analyzing data and funding strategies necessary to improve the operation of the Mississippi Statewide System of Care

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

Crisis Stabilization Unit serving children and youth is being funded in FY2024 operated by Region 2 CMHC located in Panola County. This 8-bed CSU will serve up to 4 males and 4 females.

- Youth Mental Health First Aid trainings are provided upon request to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. Mississippi's Mental Health Awareness Training Project increased mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH has partnered with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH provides training in Mental Health First Aid for Youth to educators and parents.

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

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

- Continue to collaborate with partner agencies to create and expand services for children with co-occurring disorders of serious emotional disturbance (SED) and intellectual and developmental disabilities (IDD). Work will continue to expand 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.

- Increase supports and training related to the process of high-fidelity Wraparound Facilitation throughout the state and expand intensive home- and community-based services, such as Intensive Community Support Services (ICSS) and Mississippi Youth Programs Around the Clock (MYPAC) to additional providers in the state to prevent the need for acute care and/or referrals to Psychiatric Residential Treatment Facilities.

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

- Develop statewide services and supports for children birth to 5. DMH is developing plans and investigating possible funding sources to expand Parent Child Interaction Therapy (PCIT) statewide. Currently, staff from two CMHCs (Regions 6 and 9) are participating in PCIT training provided through grant funding received by the University of Mississippi Medical Center (UMMC). Both Region 6 and Region 9 are operating PCIT pilot projects in their respective

regions. Outcomes from these pilot projects will be utilized for expansion of services and supports for children birth to 5.

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 Emergency Response Teams (MCeRTs), Crisis Intervention Teams Training (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 community mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and are trained in de-escalation techniques.
 - The DMH funds nine (9) 16-bed CSUs, three (3) 8-bed CSUs, and one (1) 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.
 - In addition to Mississippi State Hospital and East Mississippi State Hospital, DMH also operates two, 50-bed acute psychiatric hospitals for adults. The acute care/crisis services are located in the northern and southern parts 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 intensive service teams: PACT, ICORT and MCeRT.
 - The Bureau of Behavioral Health Services oversees the Peer Review Process for the DMH using The Council on Quality Leadership's Personal Outcome Measures © to assess the impact of services on the quality of life for the people receiving services. Individuals and family members are trained to conduct interviews to determine if outcomes are present for the individual and if the supports needed are present in order to achieve those outcomes. The Bureau of Behavioral Health Services maintains the commitment to ensure individuals and family members have the skills and competencies needed for meaningful participation in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs.
 - The Office of Consumer Support is responsible for maintaining a 24-hour, 7-days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide
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Prevention Lifeline. The Office of Consumer Support also responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.

- Supported Employment Sites are offered in Regions 2, 3, 4, 6, 7, 8, 9, 10, 12, 14 and 15 with a goal of offering supported employment to people with serious mental illness.
 - Trainers in both the adult and youth versions of Mental Health First Aid have been certified by the DMH. Mental Health First Aid is an education program that helps the public identify, understand, and respond to signs of mental illness, substance use disorders and behavioral disorders. These trainers provide education to community leaders including: pastors, teachers, and civic groups, and families and friends who are interested in learning more about mental health issues.
 - All DMH Behavioral Health Programs have implemented person-centered discharge practices which are aligned with the agency's transformation to a person-centered and recovery-oriented system of care.
 - The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.
 - The DMH will resume Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members once the pandemic subsides and distancing orders are lifted. ASIST can only be conducted face-to-face and is a 2-day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.
 - The Specialized Planning Options to Transition Team (SPOTT) is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.
 - Mississippi has ten (10) Programs of Assertive Community Treatment Teams (PACT) that serve the following counties: Region 3 (serves Lee and Itawamba Counties), Region 4 (serves DeSoto, Prentiss, Alcorn, Tippah, and Tishomingo Counties), Region 6 (serves Leflore, Holmes, and Grenada Counties), Region 8 (serves Madison and Rankin Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest, Perry, Harrison and Hancock Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.
 - Mississippi has sixteen (16) Intensive Outreach and Recovery Teams (ICORT) that serve the following counties: Region 2 (serves Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha), Region 6 (Washington, Bolivar, Coahoma, Quitman, Tallahatchie, Tunica), Region 7 (Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston), Region 8 (Copiah, Lincoln, Simpson), Region 9
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(Hinds), Region 10 (Clarke, Leake, Newton, Smith, Scott), Region 12 (Covington, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Pike, Lawrence, Walthall, Franklin, and Amite.), Region 14 (George, Jackson), and Region 15 (Adams, Wilkinson, Claiborne, and Jefferson).

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

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. DMH applied for a recent SAMHSA grant to fund expansion of the IPS model to those regions currently operating Supported Employment Expansion Sites. Currently, Regions 2, 4, 7, 8, 9, 10, and 12 operate Supported Employment IPS Sites. Regions 1, 3, 6, and formerly 11 (now Regions 12 and 15) operate Supported Employment Expansion Sites. The goal is to further develop and support evidence-based opportunities and resources for employment of those struggling with mental health challenges.

- 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, correctional officers, volunteer fire departments and first responders. The DMH makes grant funding available to the Lauderdale County Sheriff's Department to provide training to law enforcement to facilitate the establishment of Crisis Intervention Teams (CIT) throughout the state. Additionally, DMH provides funding through a SAMHSA grant to Region 12, Pine Belt Mental Healthcare Resources, for CIT expansion in the southern half of the state.
 - Continued focus on improving transition, supports, and care coordination for individuals transition from behavioral health programs back to their community-based services. The development
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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.

- Ongoing and continued efforts to improve data quality, analysis, and consistency are currently being implemented and monitored. The goal is to integrate new and existing data into a comprehensive quality improvement system.

Underserved Racial and Ethnic Minority and LGBTQ+ Populations

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

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 and services on the Mississippi Behavioral Health Planning and Advisory Council. The mission of Multicultural Task Force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. In turn, staff from DMH participates and assists in planning the Annual Youth Conference sponsored by Choctaw Behavioral Health Services. The local governance council with a System of Care community also includes a representative from the Mississippi Band of Choctaws Behavioral Health Services. An individual interested in or in need of mental health services can find contact information for the Mississippi Band of Choctaws Behavioral Health Services on the current Mississippi Department of Mental Health Website.

Persons with Disabilities

Children and youth with disabilities, such as hearing and/or visual impairments, are served initially by local MAP (Making a Plan) Teams. If local resources are unavailable, the child or youth is referred to the State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, and includes representatives from the Department of Mental Health; the Department of Child Protection Services; the Division of Medicaid; the Attorney General's Office; the Department of Health; the Department of Education, the Department of Rehabilitation Services and Families As Allies for Children's Mental Health. The team meets once a month and on an as needed or emergency

basis to review cases and/or discuss other issues relevant to children’s mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need specialized or support services. Representatives from the Mississippi School for the Deaf and Blind participate as needed on the team and work in collaboration with staff from the Division of Children and Youth Services to develop appropriate plans to meet the needs of children and youth in our state with hearing and visual challenges.

Military Men and Women

While our military and its members are strong, there are times when they too struggle with stress, anxiety, depression and even thoughts of suicide. Sometimes military men and women feel embarrassed or ashamed to seek help and others may not know what help is available. Members of the military make a promise to protect our country. Mississippians are now making a promise to support them when they are on and off the field of battle. The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families. The campaign, Operation Resiliency, reaches National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. Stress can be a part of everyday life for many people. However, members of the military can face a constant and severe stress that many civilians may never know. It can lead to depression, anxiety, relationship problems, aggression, thoughts of suicide, financial problems, accidents, alcohol and drug use, domestic violence, and hopelessness. It is important for members of the military to understand when to seek help. Through our partnership with the National Guard, the Department of Mental Health is a frequent presenter of Shatter the Silence: Suicide-The Secret You Shouldn’t Keep at Yellow Ribbon events throughout the state that reach thousands of returning soldiers and their family members. The presentation is customized to the audience and teaches mental health awareness, risk factors and warning signs for suicide, and resources available to help a person in suicidal crisis.

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

- The Mississippi Department of Mental Health
 - The Mississippi National Guard
 - Mississippi Veterans Affairs
 - G.V. Sonny Montgomery VA Medical Center
 - Mississippi Attorney General’s Office
 - The U.S. Department of Veterans Affairs
 - Mississippi State University Department of Psychology and Extension Services
 - Leadership from veteran, military family, and caregiver organizations
 - Private sector providers and peer support specialists
- i. The purpose of the challenge is to develop and implement state-wide suicide prevention best practices for Service Members, Veterans, and their Families (SMVF), using a public health approach. The objectives of the challenge are to: Implement promising, best, and evidence-based practices to prevent and reduce suicide.
 - ii. Engage with city, county, and state stakeholders to enhance and align local and state-wide suicide prevention efforts.
 - iii. Understand the issues surrounding suicide prevention for SMVF.
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- iv. Increase knowledge about the challenges and lessons learned in implementing best policies and practices by using state-to-state and community-to-community sharing.
- v. Employ promising, best, and evidence-based practices to prevent and reduce suicide at the local level.

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

Priority Area 1: Identifying SMVF and Screening for Suicide Risk

Priority Area 2: Promoting Connectedness and Care Transitions

Priority Area 3: Lethal Means Safety and Safety Planning

Statutory Criterion for Mental Health Block Grant (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 Emergency Response Teams (MCeRTs), Crisis Intervention Teams Training (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 11-community mental health center regions. CIT teams are located in Desoto County, Jones County, Lauderdale County, Lee County, Lafayette County, Pearl River County, Forrest County, Lamar County, Pike County, and Harrison County.

Crisis Stabilization Units

The DMH funds nine (9) 16-bed CSUs, three (3) 8-bed CSUs, and (1) 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. In addition, Supervised and Supported Housing provides mental health services in group homes for individuals with SMI that are staffed 24 hours and apartments that are owned or leased by the CMHC and then re-rented to their clients with ongoing visits and support from CMHC staff.

PACT Teams

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

ICORT

Mississippi has sixteen (16) Intensive Outreach and Recovery Teams (ICORT) that serve the following counties: Region 2 (serves Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha), Region 6 (Bolivar, Coahoma, Quitman, Tallahatchie, Tunica, and Washington), Region 7 (Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston), Region 8 (Copiah, Lincoln, Simpson), Region 9 (Hinds), Region 10 (Clarke, Leake, Newton, Smith, Scott), Region 12 (Amite, Covington, Franklin, Jefferson Davis, Jones, Lamar, Lawrence, Marion, Pearl River, Pike, and Walthall), Region 14 (George, Jackson), and Region 15 (Adams, Claiborne, Jefferson, and Wilkinson).

Supported Employment

Supported employment services are offered at every CMHC for adults living with mental illness in Mississippi. The DMH collaborates with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental illness. Currently, in addition to the 4 pilot sites initially funded, supported employment is now being provided in regions 2,3,4,6,8,9,14, and 15. Regions 4,8, and 9 transitioned to IPS Sites in FY22. Currently, Regions 2, 4, 7, 8, 9, 10, and 12 operate Supported Employment IPS Sites. Regions 1, 3, 6, and formerly 11 (now Regions 12 and 15) operate Supported Employment Expansion Sites. The goal is to further develop and support evidence-based opportunities and resources for employment of those struggling with mental health challenges.

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 11 of our CMHCs.

Psychosocial Rehabilitation Services (PSR)

Psychosocial Rehabilitation Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills, and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal, and feelings of low self-worth. PSR is a core service and is offered at the 11 CMHCs.

Recovery Supports

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

system of care. DMH also supports the operation of the Association of Mississippi Peer Support Specialists (AMPSS).

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

Children and Youth

The most current Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI released in September 2022 (April 1, 2020 - July 1, 2021) 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 2021 is 367,979. Mississippi remains in the group of states with the highest poverty rate (18.6% 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 2021 are as follows:

- Mississippi’s estimated prevalence range for children and adolescents, ages 9 – 17 years, with serious emotional disturbance (SED) ranges between 7% (25,759 youth) to 13% (47,837) dependent on level of functioning.

Adults

The most current published Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI released in September 2022 (April 1, 2020 - July 1, 2021) was utilized to calculate the estimate of prevalence of serious mental illness (SMI) among adults in Mississippi. According to URS Table 1, there are 2,244,643 adults in Mississippi (ages 18 years and older). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2021, ages 18 years and older, is 121,211 (5.4%) with a lower limit estimate (3.7%) of 83,052 and an upper limit estimate (7.1%) of 159,370.

The Mississippi Department of Mental Health reported the following information to SAMHSA for FY22 URS reporting (July 1, 2021 – June 30, 2022) for both children and youth and adults. The following information is related to certified providers only reporting data through Data Warehouse. Approximately 25,204 children and youth ages 0 – 17 years old were identified with SED and approximately 51,317 individuals 18 – 75 years + identified as having a SMI. Approximately 44% of children and youth with SED identified as female and 55% identified as male, with less than 1% identifying as “other.” Additionally, 54% identified as Black/African American and 40% as White. Approximately 56% of adults with SMI identified as female and 43% identified as male, with less than 1% identifying as “other.” Additionally, 50% of adults with SMI identified as Black/African American and 48% as White.

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 11 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. Community-based processes and services 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, Mississippi Youth Programs Around the Clock, (MYPAC), Wraparound Facilitation, Day Treatment Services, 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 are a major focus of the Department of Mental Health including the Division of Children and Youth Services. Division of Children and Youth Services aims to work with the Behavioral Health Planning and Advisory Council to support statewide services for SED. The goal is for interagency collaboration and coordination to exist at the state level and in local and regional areas, encompassing needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives explained below are the Interagency Coordinating Council for Children and Youth (ICCCY), State-Level Interagency Case Review/ MAP Team, the Making a Plan (MAP) Teams, and participation in a variety of state-level interagency councils and committees that focus on the needs of children and youth.

The ICCCY was enacted into law as the coordinating entity to oversee the system of care for children's mental health in Mississippi in 2001 through legislation, and in 2010 the legislature passed HB 1529, which expanded its membership and further defined its duties. The ICCCY is designated to meet twice yearly to coordinate Mississippi's System of Care. Due to a lack of funding and a mandate to rotate the chairmanship of the Council annually among the various agencies, meetings ceased. Collaboration between the Executive Directors of Families As Allies and the Department of Mental Health resumed ICCCY meetings in June of FY21. The membership consists of: State Superintendent of Public Education; Executive Director of the Mississippi Department of Mental Health; Executive Director of the State Department Health; Executive Director of the Department of Human Services; Executive Director of the Division of Medicaid, Office of the Governor; (Executive Director of the State Department of Rehabilitation Services; Executive Director of Mississippi Families as Allies for Children's Mental Health, Inc.; Attorney General; a family member of a child or youth in the population named in this chapter designated by Mississippi Families as Allies; a youth or young adult in the population named in

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

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

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Non-profit children's behavioral health providers, local law enforcement, youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. This wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 11 community mental health regions across the state.

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 to fund state-wide training on Wraparound Facilitation for providers of children/youth services including the community mental health centers, five non-profit organizations, parents, and social workers. The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work for the Mississippi Wraparound Institute (MWI). MWI has two nationally certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly

trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. In FY22, 1,887 children and youth took part in the process of Wraparound.

NAVIGATE

Coordinated Specialty Care (CSC) Teams are offered in four areas of the state for youth and young adults experiencing first episode psychosis (FEP) through an evidence-based program called NAVIGATE. Regions 2,4,6,7,8,9, 14 and 15 provide an array of services to youth and young adults with FEP including individual and family therapy and education, medication management, and assistance to achieve educational and work-related goals. Team members, that provide the majority of services for these youth and young adults in the community, include a Team Leader/Family Education Clinician, an Individual Resiliency Training Clinical, a Supported Employment/Education Specialist, a Prescriber, and for most programs, a Peer Support Specialist. In FY 22, 83 youth and young adults were served through NAVIGATE.

Youth Mental Health First Aid

DMH trainers provide trainings upon request to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. In June 2017, the first group of Mental Health First Aid trainers received supplemental training. A federal grant from the Substance Abuse and Mental Health Services Administration in 2018 has enabled DMH to offer mental health training and education to schools and educators throughout the state. Mississippi's Mental Health Awareness Training Project is increasing mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH is partnering with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH provides training in Mental Health First Aid for Youth to educators and parents. In FY 22, twenty-three (23) YMHFA trainings were provided. In these twenty-three YMHFA trainings that were offered, 130 participants were trained. There were 8 school districts represented by participants in the trainings. A staff in the Division of Children and Youth continues to maintain their certification as an ASIST trainer.

Initiatives to Assure Transition to Adult Mental Health Services

The Bureau of Behavioral Health Services has made a concerted effort to better address issues of youth transitioning from the child to the adult system. The Executive Steering Committee has focused on expanding the age range of children/youth identified as transitional age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system.

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 for youth over 18 years old.

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. OPEN UP Mississippi is a mental health youth advocacy group with a purpose of removing the stigma that prevents youth and young adults from seeking mental health services, promoting mental health awareness, and providing advocacy services specifically for youth and young adults ages 18-26 years.

Support for Services for Youth with Co-occurring Disorders

DMH has implemented Adolescent Intensive Outpatient Programs serving youth with co-occurring disorders utilizing evidence-based practices such as Adolescent Community Reinforcement Approach, Wraparound Facilitation, and the GAIN assessment system.

Additionally, the Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance use problems which also address problems of youth with co-occurring disorders.

Criterion 4: Targeted Services to Rural and Homeless Populations

Mississippi maintains 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 homeless and/or living in places not meant for human habitation. Peer Support Specialists provide street outreach to maintain consistent and continual contact with consumers. Peer Support Specialists utilize lived experience to help homeless individuals reconcile that recovery is attainable and supports and resources are available to provide housing, employment, and stability opportunities. The PATH program provides the state with funds for flexible community-based services for persons with serious mental illnesses and co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. DMH provides funding to 4 CMHCs and 1 non-profit provider.

The DMH staff continues to participate with partners in the continuum of Care (CoC) to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. Staff attends the Central MS CoC meetings as well as the Open Doors CoC meetings. The CHOICE Program works collaboratively with the Mississippi Department of Health, Mississippi's Community Mental Health Centers, and Mississippi Home Cooperation to provide intensive case management and temporary rental assistance to make housing affordable throughout the state of Mississippi for individuals with serious mental illness. In FY22, 239 people were served through CHOICE. At the end of June 2022, 130 people were enrolled in CHOICE housing. All the people housed through CHOICE are recipients of CMHC services. In FY22, 121 new clients were housed; Mississippi United to End Homelessness (MUTEH) housed 60 people and Open Doors Homeless Coalition housed 61. There were 73 housed through CHOICE in the first half of FY22, and 48 housed in the second half of FY22.

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

Mental Health Federal Block Grant Award FY 2023	
Administration Amount	\$439,497
Amount to be awarded	\$8,789,930
FEP Set Aside (10%) C&Y	\$878,993
Crisis Set Aside (5%) Adult	\$439,497
Children's portion	\$1,659,220
Adult portion	\$5,372,723



Substance Use Disorder Prevention, Treatment, and Recovery Support

The Department of Mental Health, Bureau of Behavioral Health Services is comprised of the Divisions of Alcohol and Drug Addiction Treatment Services, Alcohol and Drug Addiction Prevention Services, and Peer Support and Recovery Services. These divisions support the administration of the public system of substance use disorder assessment, referral, prevention, treatment, and recovery support services for the individuals it is charged to serve. It is also responsible for establishing, maintaining, and evaluating the network of service providers which include state-operated behavioral health programs, regional community mental health centers, and other nonprofit community-based programs.

The Bureau of Behavioral Health Services strives to achieve and/or maintain high standards through the service delivery systems across the state. Therefore, the bureau is mandated to establish standards for the state's alcohol/drug prevention, treatment, and recovery support programs; assure compliance with these standards; effectively administer the use of available resources; advocate for and manage financial resources; develop the state's human resources by providing training opportunities; and develop an alcohol/drug data collection system. In order to address the issues of substance use disorders, the bureau believes a successful program is based on the following philosophical tenets:

- Substance use disorders are illnesses which are treatable and preventable.
- Effective prevention services reduce, delay, and prevent substance abuse. It decreases the need for treatment and provides for a better quality of life.
- Substance use disorders are prevalent in all culturally diverse subgroups and socioeconomic categories.
- Services should be delivered in a community setting, if appropriate.
- Continuity of care is essential to an effective substance use disorder treatment program.
- Vocational rehabilitation is an integral part of the recovery process.
- Effective treatment and recovery include delivery of services to the individual and his/her family.
- Individuals in recovery from a substance use disorder can return to a productive role within their community.

The network of services comprising the public substance use disorder treatment system is provided through the following avenues:

Regional Community Mental Health Centers

The CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 11 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.

Community Mental Health Centers are the primary service providers of the public substance use disorders services delivery system. Each CMHC serves a designated number of Mississippi counties. There are sixty-seven community-based satellite centers throughout the state which allow greater access to services by the area's residents.

The goal is for each Community Mental Health Center to have a full range of treatment options available for citizens in its region. Substance use disorders services usually include: (1) alcohol, tobacco, and other drug prevention services; (2) general outpatient treatment including individual, group, and family counseling; (3) recovery support (continuing care) planning and implementation services; (4) high-

intensity residential treatment services (including withdrawal management); (5) low-intensity residential treatment services; (6) vocational counseling and employment seeking assistance; (7) emergency services (including a 24-hour hotline); (8) educational programs targeting recovery from substance use disorders which include understanding the disease, the recovery process, relapse prevention, and anger management; (9) recreational and social activities presenting alternatives to continued substance use and emphasizing the positive aspects of recovery; (10) 10-15 week intensive outpatient treatment programs for individuals who are in need of treatment but are still able to maintain job or school responsibilities; (11) community-based residential substance use disorders treatment for adolescents; (12) specialized women's services; (13) priority treatment for pregnant/parenting women; (14) services for individuals with a co-occurring disorder of substance use disorder and serious mental illness; and, (15) employee assistance programs.

Other Nonprofit Service Agencies/Organizations

Other Nonprofit Service Agencies/Organizations, which make up a smaller part of the service system, also receive funding through the Department of Mental Health to provide community-based services. Many of these free-standing nonprofit organizations receive additional funding from other sources such as grants from other state agencies, community service agencies, donations, etc.

Process for Funding Community-Based Services

Within the Department of Mental Health, the Bureau of Behavioral Health's Divisions of Alcohol and Drug Addiction Prevention, Treatment, and Recovery Support Services are responsible for administering the fiscal resources for substance use disorder services. The authority for funding programs to provide services to persons in Mississippi with substance use disorder issues was established through state statute.

Funding is provided to community service providers by the Department of Mental Health through purchase Proposals and Application of Services (POS) or grant mechanisms. Funds are allocated by the Department through a Request for Review Process. Requests for Proposals (RFPs) and/or Funding Continuation Applications (FCAs) are disseminated among service providers through the Department's Grants Management office and detail all requirements necessary for a provider to be considered for funding. The RFP/RFC may also address any special requirements mandated by the funding source, as well as Department of Mental Health requirements for programs providing substance use disorders services.

Agencies or organizations submit proposals which address needs of prevention and treatment services in their local communities to DMH for their review. Applications for funding of prevention or treatment programs are reviewed by Bureau of Behavioral Health, Divisions of Alcohol and Drug Addiction Prevention and Treatment Services staff, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP/RFC, (2) the applicant's provision of services' compatibility with established priorities, and (3) availability of resources.

Sources of Funding

Sources of funding for substance use disorders prevention and treatment services are provided by both state and federal resources.

Federal Sources

Substance Abuse Mental Health Services Administration

The Substance Use Block Grant (SUBG) is applied for annually by the DMH, Bureau of Behavioral Health Services. Detailed goals and objectives for addressing specific federal requirements included in the SUBG program are included in this State Plan. The Substance Use Block Grant is the primary funding

source for DMH to administer substance use disorders prevention and treatment services in Mississippi. The Bureau allocates these awarded funds to its programs statewide. Funds are used to provide the following services: (1) general outpatient treatment; (2) intensive outpatient treatment; (3) high-intensity residential treatment; (4) low-intensity residential treatment; (5) peer recovery support services; (6) prevention services; (7) community-based residential substance use disorders treatment for adolescents; (8) special women's services which include day treatment and residential treatment with priority on recovery support activities and programs for pregnant women and women with dependent children; (9) DUI assessment, opioid treatment services, and withdrawal management services for individuals with a co-occurring disorder. In administering SUBG funds, the DMH Bureau of Behavioral Health Services maintains minimum required expenditure levels (set aside) for substance use disorders services in accordance with federal regulations and guidelines.

State Sources

Alcohol Tax

In 1977, the Mississippi Legislature levied a three percent tax on alcoholic beverages, excluding beer, for the purpose of using these tax collections to match federal funding, as deemed necessary, in order to fund alcohol treatment and rehabilitation programs. The earmarked alcohol tax is tied directly to the volume of alcoholic beverages sold in the state. Funds from the three percent alcohol tax are used to provide treatment for alcohol use disorders at DMH operated behavioral health programs and community-based programs.

The components of the substance use disorder prevention and treatment service system are aligned with the Department of Mental Health's Strategic Plan. The components encompass the strategic plan's nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training, and information management.

Rehabilitation/Treatment Services

Treatment Modalities

The Bureau of Behavioral Health encourages "Best Practices" that aim to investigate the potential problem of substance use disorders and motivate the individual to do something about it either by natural, client-directed means or by seeking additional treatment. This can be done by utilizing brief interventions in an outpatient setting, which is the most common modality of treatment. A Level of Care Placement Assessment (*in accordance with The ASAM Criteria*) is administered to determine if a more intense level of treatment is recommended. Some evidence-based practices currently being utilized in treatment are brief interventions, group-based approaches to therapy, Cognitive-Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, Applied Suicide Intervention Skills Training, Trauma Focused-Cognitive Behavioral Therapy, and 12 Step Facilitation.

Family Support

For many individuals with substance use disorders, interaction with their family is vital to the recovery process. The family has a vital role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the user relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access, and knowledge of the referral and placement process.

Access to Community-Based High-Intensity Residential Services

Level 3 Residential Programs (3.3, 3.5, and 3.7) are a twenty-four hour, seven days a week on-site residential program for adult males and females who have substance use disorders. This type of treatment



is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive.

Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services offers 24-hour support setting to meet the needs of people with cognitive difficulties, who need specialized individualized treatment services (who need a slower pace and could not otherwise make use of the more intensive Level 3.5 milieu). This level of care is not a step-down residential level. It is qualitatively different from other residential levels of

care. The cognitive impairments manifested in individuals most appropriately treated in Level 3.3 services can be due to aging, traumatic brain injury, acute but lasting injury, or due to illness.

Level 3.5 Clinically Managed High-Intensity Residential Services (for adults) is designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. This level of care offers organized treatment services that feature a planned and structured regimen of care in a 24-hour residential setting. Additionally, this level of care is based on the patient's severity of illness, level of function, and progress in treatment. Predetermined minimum lengths of stay or overall program lengths of stay that must be achieved in order for a patient to "complete treatment" or "graduate" are inconsistent with an individualized and outcomes-driven system of care. The duration of treatment in this level of care always depends on an individual's progress in acquiring basic living skills.

Level 3.7 Medically Monitored Intensive Inpatient Services (for adults) offers 24-hour nursing care with physician availability for significant problems in Dimension's 1, 2, or 3 with a 16-hour/day counselor ability. Additionally, this level of care is based on the patient's severity of illness, level of function, and progress in treatment. The duration of treatment in this level of care always depends on an individual's progress in acquiring basic living skills.

Although all substance use disorders treatment programs are accessible to pregnant women, there are two specifically designed for this population. Additionally, there are high-intensity residential treatment programs tailored for adolescents and for persons in the criminal justice system. The Bureau of Behavioral Health Services supports specialized services for the following populations:

Specialized High-Intensity Residential Services for Pregnant Women and Women with Dependent Children: In addition to traditional treatment modalities described above, these programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

SUBG-funded Providers are required to respond within 48 hours of a pregnant injecting drug user, a pregnant substance user/abuser, parenting male or female injecting drug users, parenting male, or female substance user/abuser, and uninsured/under insured pregnant or parenting men and women (PPMW) seeking treatment. Therefore SUBG-funded providers must, if no treatment facility has the capacity to admit the pregnant woman, make available interim services, including a referral for prenatal care, available, to the pregnant woman no later than 48 hours after the pregnant woman seeks treatment services. **Specialized Medium-Intensity Residential Services for Adolescents:** While providing many of the same therapeutic, informational/educational, and social/recreational services as adult programs, the content is modified to accommodate the substance using adolescent population. Adolescent treatment

programs are generally longer in duration than adult high-intensity residential programs. Some allow the client to remain from six months to a year, depending on several factors that may include the program's recommendations, parental participation, and the client's progress and adaptability. Also, all programs provide regularly scheduled academic classes individually designed for each client following a MS Department of Education approved curriculum by an MDE certified teacher.

The Department of Mental Health's (DMH) Bureau of Behavioral Health Services (DADATS) will continue to certify and provide funding to support ten (10) community-based primary residential treatment programs for adult females and males. Four (4) free-standing programs are certified by the DMH, making available a total of fourteen (14) primary residential substance use treatment programs located throughout the 11 community mental health regions. While all of the programs serve pregnant women, there are two specialized programs that are equipped to provide services for the duration of the pregnancy. In addition to the substance use disorder treatment, these specialized primary residential programs will provide the following services: 1) primary medical care including prenatal care and childcare; 2) primary pediatric care for their children including immunization; 3) gender specific substance use treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, parenting, and child care while the women are receiving these services; 4) therapeutic interventions for children in custody of women in treatment which may, among other things address their developmental needs and issues of sexual and physical abuse and neglect; 5) sufficient case management and transportation services to ensure that women and their children have access to the services provided in (1) through (4). The DMH Operational Standards require that all substance use programs must document and follow written policies and procedures that ensure: • Pregnant women are given priority for admission; • Pregnant women may not be placed on a waiting list. Pregnant women must be admitted into a substance abuse treatment program within forty-eight (48) hours; • If a program is unable to admit a pregnant woman due to being at capacity; the program must assess, refer, and place the individual in another certified DMH certified program within 48 hours; • If a program is unable to admit a pregnant woman, the woman must be referred to a local health provider for prenatal care until an appropriate placement is made; • If a program is at capacity and a referral must be made, the pregnant woman must be offered an immediate face to face assessment at the agency or another DMH certified provider. If offered at another DMH certified program, the referring program must facilitate the appointment at the alternate DMH certified program. The referring provider must follow up with the certified provider and program to ensure the individual was placed within forty-eight (48) hours.

Level 3.5 Clinically Managed Medium-Intensity Residential Services (Adolescents) Residential Services is the highest community-based level of care for the treatment of substance use/addictive disorders. This level of treatment provides a safe and stable group living environment where the individual can develop, practice, and demonstrate necessary recovery skills. Residential Services provides residential care and comprehensive treatment services for adolescents whose problems are so severe or are such that they cannot be cared for at home or in foster care and need the specialized services provided by specialized facilities. Comprehensive services and activities may include diagnosis and psychological evaluation; alcohol and drug withdrawal management (detoxification) services; individual, family, and group therapy/counseling; remedial education and GED preparation, vocational or pre-vocational training; training on activities of daily living; supervised recreational and social activities; case management; transportation; and referral to utilization of other services.

Specialized Services for Persons in the Criminal Justice System: Substance use disorders screening and a high-intensity treatment unit are provided for the inmates at the Mississippi Correctional Facility.

Access to Community-Based Low-Intensity Residential Services

Level 3.1 (Transitional) Clinically Managed Low-Intensity Residential Services Program is a less intensive program for adult males and females, who typically remain from two to six months depending

on the individual needs of the client. Level 3.1 Clinically Managed Low-Intensity Residential Services provide a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational correlated opportunities. Level 3.1 Residential Services are staffed 24 hours a day. This level of care requires a minimum a five (5) hours of treatment per week. The length of stay is based on the individual's severity of illness, level of function, and progress in treatment. The duration of treatment in this level of care always depends on an individual's progress in acquiring basic living skills. Intended to be an intermediate stage between high-intensity residential treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive and fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid in the pursuit and acquisition of vocational, employment, and/or related activities. Although all substance use disorder treatment programs are accessible to pregnant women, there are two specifically designed for this population. There are also programs that provide services for female ex-offenders and adult males who have been diagnosed with a co-occurring disorder.

Specialized Low-Intensity Residential Services for Pregnant Women and Women with Dependent Children: These programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. In addition to traditional therapeutic activities, the treatment program also focuses on parenting skills education, nutrition, medical, and other needed services.

Specialized Low-Intensity Residential Services for Female Ex-offenders: This program provides immediate support for women leaving high-intensity treatment programs in correctional facilities.

Access to Community-Based Outpatient Services

Each program providing substance use disorder outpatient services must provide multiple treatment modalities, techniques, and strategies which include individual, group, and family counseling. Program staff must include professionals representing multiple disciplines who have clinical training and experience specifically pertaining to the provision of substance use disorders.

Level 1 Outpatient: This program is appropriate for individuals whose clinical condition or environmental circumstances do not require an intensive level of care. The duration of treatment is tailored to individual needs and may vary from a few months to several years.

General Outpatient Services for Opiate Addiction: The Bureau of Behavioral Health Services in collaboration with the Center for Substance Abuse Treatment (CSAT) continues its relationship in addressing issues of treatment for individuals who are addicted to prescription pain medications and patients who are addicted to heroin and other opiates. The State Methadone Authority (SMA) works closely with the State's opiate

replacement program to support programs which stress the core values of opiate treatment including the right of the individual to be treated with dignity and respect.

Level 2.1: Intensive Outpatient Program (IOP) for Adults: This program provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three



times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week.

Specialized Intensive Outpatient Services for Adolescents: These programs operate in the same manner as those described above but focuses on the special needs of adolescents. The program allows the young person to maintain responsibilities related to education, family, employment, and community while receiving treatment.

Access to Hospital-Based Inpatient Chemical Dependency Unit Services

Inpatient or hospital-based programs offer treatment and rehabilitation services for individuals whose substance use problems require a medically monitored environment. These may include: (a) patients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting; (b) patients in withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes withdrawal management, assessment and evaluation, intervention counseling, aftercare, a family support program, and referral services.

Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance use. The program is designed to break the cycle of being frequently hospitalized by treating the substance use simultaneously with the mental illness.

Support Services

Access to Recovery Support Services

A key component to a Person-Centered Recovery Oriented System of Care is Recovery Support Services and Peer Recovery Support Services. Recovery Support Services and Peer Recovery Support Services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. These services include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. Recovery Support Services and Peer Recovery Support Services may be provided in conjunction with treatment and/or separate and distinct services to individuals and families who desire and need them. Recovery Support Services and Peer Recovery Support Services may be delivered by peers, professionals, faith-based and community-based groups, and others designated to help individuals stabilize and sustain their recovery. They also may provide structured support and assistance to the client in making referrals to secure additional needed services from community mental health centers or from other health or human services providers while maintaining contact and involvement with the client's family. Research indicates that strong social supports assist recovery and recovery outcomes. Since many of these services are delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge.

Access to Services for the Older Adult

Services are provided to the older adult with substance use disorder issues and/or their families by providing information and access to needed treatment. Alcohol and prescription drug misuse and abuse are prevalent among older adults due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. Substance dependence is directly correlated with other potential causes of cognitive impairment. Coupled with drug addiction and cognitive impairment, they should be encouraged to seek appropriate treatment. Counselors often use the opportunity to educate the older adult and to help them to acknowledge their addiction. Patient

understanding and cooperation for the older adult are essential in eliciting accurate information in order to carry out the appropriate type of treatment. Depending on the individual's particular situation, the person's needs may change over time and require different levels and intensities of rehabilitation.

DUI Diagnostic Assessment Services

Diagnostic Assessment Services are for individuals who have been convicted of two or more DUI violations which have resulted in the suspension of their driver's license. The DUI (Driving Under the Influence) Diagnostic Assessment is a process by which the diagnostic assessment, Substance Abuse Subtle Screening Inventory (SASSI) is administered, and the result is combined with other required information to determine the offender's appropriate treatment environment for second and subsequent offenders.

The diagnostic assessment process ensures the following steps are taken. First, an approved DMH diagnostic assessment instrument is administered. Second, the results of the initial assessment along with the DMH Substance Abuse Specific Assessment are evaluated. Third, the Blood Alcohol Content (BAC) and the motor vehicle report are reviewed. And last, collateral contacts along with other clinical observations, if appropriate, are recorded. After this process is completed, the DUI offender is placed or referred to the appropriate treatment environment for services. The Division of Alcohol and Drug Addiction Treatment Services will monitor the numbers of offenders seeking services by reviewing the Certification of DUI In-Depth Diagnostic Assessment and Treatment Program Completion Forms, DUI Data System, and the Central Data Repository (CDR).

Mississippi Drug Courts

Mississippi currently has 40 drug courts covering all 82 counties. There are 22 adult felony programs, 3 adult misdemeanor programs, 12 juvenile programs, and 3 family programs. The mission of the drug court is to establish a system with judicial requirements which will effectively reduce crime by positively impacting the lives of substance users and their families. The target population of the program is for anyone whose criminal behaviors are rooted in their substance use. An evaluation process determines whether or not an offender is eligible for the program.

Currently, the Bureau of Behavioral Health Services allocates funding to support a private, non-profit, free-standing community-based program to implement the ICMS's (Intensive Case Management Services) phase of the Drug Court Program. The case managers work closely with the court system to assist the client in meeting the judicial requirements administered by the court. Clients are offered the incentive of a chance to remain out of jail and the sanction of a jail sentence if they fail to remain drug-free and noncompliant. The BBH/AS, Director of Prevention Services, serves on the State Drug Court Advisory Committee.

Vocational Rehabilitation Services

Each high-intensity residential treatment program provides vocational counseling to individuals while they are in the treatment program. In low-intensity residential treatment, the primary focus is assisting the client in securing employment and/or maintaining employment. The Department of Rehabilitation Services, Office of Vocational

Rehabilitation, partners with the Bureau of Behavioral Health Services in providing some monetary support for eligible individuals in the low-intensity residential treatment programs.

Tuberculosis and HIV/AIDS Assessment/Educational Services



All individuals receiving substance use disorder treatment services are assessed for the risk of tuberculosis and HIV/AIDS. If the results of the assessment indicate the individual to be at high risk for infection, testing is made available. Individuals also receive educational information regarding HIV/AIDS, STDs, TB, and Hepatitis either in individual or group sessions during treatment.

Referral Services

For many years the Bureau of Behavioral Health, Divisions of Alcohol and Drug Addiction Prevention, Treatment, and Recovery Support Services has published the Mississippi Alcohol and Drug Prevention and Treatment Resources Directory for the public to access substance use disorder services. The directory is comprised of all DMH certified substance use treatment and prevention programs as well as other recognized programs across the state of Mississippi. It is revised, updated, and redistributed by the Bureau of Behavioral Health, Divisions of Alcohol and Drug Addiction Prevention, Treatment, and Recovery Support Services every three years. The 2017-2019 publication was distributed in August of 2017 to treatment facilities, human services organizations, and a wide variety of other interested parties statewide. The manual is extensively used for a variety of referral purposes. Approximately 5,000 copies have been distributed throughout the United States over the past few years. In addition, individuals seeking referral information through the Department of Mental Health may do so by contacting a toll-free help line, operated by the DMH Office of Consumer Support.

Prevention Services

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco, and other drug abuse. Based on identified risk and protective factors, these activities must be carried out in an intentional, comprehensive, and systematic way to impact large numbers of people.

Most substance use disorder prevention programs today are targeted at youth; however, the prevalence of substance use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use disorders determine, to a large extent, the environment in which choices will be made about use by children and adolescents. Therefore, the Bureau of Behavioral Health Services supports prevention services that target adults as well as young people.

The causes of substance use disease are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and social media often promote or convey acceptance of drug use behaviors. These factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in several ways. The Division of Alcohol and Drug Addiction Prevention Services requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental. (The definition of each strategy may be found at <http://oregonpgs.org/wp-content/uploads/2016/07/6csap-strategies>).

Through the Bureau of Behavioral Health, Division of Alcohol and Drug Addiction Prevention Services, Mississippi has made great strides in improving the prevention delivery service system during the past five

years. The Division-of Alcohol and Drug Addiction Prevention Services has instituted many new policies for sub-grantees funded by the 20 percent prevention set aside of the SUBG. Two examples include: 1) designation of an individual to coordinate prevention services, and 2) requiring each program to implement at least one evidence-based program. All prevention services providers implement age appropriate, evidence-based curriculums and activities to youths ages K-College. Schools, Churches Boys and Girls Clubs are the primary targeted populations. Colleges and University campuses are considered a major target because of the popularity of the partying and tailgating cultures here in Mississippi.

The Strategic Prevention Framework-State Incentive Grant (SPF-SIG), awarded to the Division of Alcohol and Drug Addiction Prevention Services in 2001, allowed the Division of Alcohol and Drug Addiction Prevention Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Behavioral Health Services received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals:

(1) Build prevention capacity and infrastructure at state and community levels; (2) Prevent the onset and reduce the progression of substance use, including childhood and underage drinking; and (3) Reduce substance use-related problems in communities. In 2012 the Division of Alcohol and Drug Addiction Prevention Services was awarded the Partnership for Success II Grant from SAMHSA/CSAP which will continue to combat underage drinking and related consequences but also target the reduction of prescription drug abuse rates and consequences for youth and young adults.

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 Central 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.

Mississippi's Single State Agency (SSA) serves all eighty-two counties via a workforce and infrastructure that consist of 11 Community Mental Health Centers (CMHCs) and 10 Free Standing service providers. This workforce receives annual training and continuing education via workforce development contract/provider that has more than thirty years of experience providing continuing education opportunities at no cost to (SSA) certified community level programs and providers. These opportunities are also available to non-certified providers at a cost \$25 per course. Current trends in substance use, social services and social media concepts are among the topics of focus for the workforce.

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. FY 23 - FY27 DMH Strategic Plan includes six goals: To provide efficient and effective inpatient services for

adolescents and adults with serious mental illness and/or substance use disorders; To maximize the efficiency and effectiveness of community services and supports that prevent unnecessary hospitalizations for children, youth, and adults; To improve connections to care and the effectiveness of the crisis services continuum network of services statewide; 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; To develop and build capacity of the behavioral health and IDD workforce; To engage Mississippians and promote the development of effective educational resources and dissemination approaches to improve public understanding of behavioral health. 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 Behavioral Health Planning and Advisory Council and the Mississippi Board of Mental Health. The DMH has benefited greatly from the continuity of its relationship with the Mississippi State Behavioral Health Planning and Advisory Council, which includes representation from integral and significant 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. The Behavioral Health Planning and Advisory Council developed and disseminated a consumer feedback survey targeted to reach all Mississippians and gauge their needs and understanding of the mental health and substance use system in the state. DMH plans to work collaboratively with the Behavioral Health Planning and Advisory Council over the next several years to comprehensively address the identified areas of need noted by Mississippians. Family members, consumers, local service providers, and representatives from other agencies participate on numerous task forces and coalitions.

DMH has been working to develop, implement, and monitor data driven means and analytics to support funding prioritization and service development. Data and community feedback driven metrics are the current and future focus of DMH to ensure appropriate and adequate service supports and provision.

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 America 2023 – Ranking the States as well as the identified themes in the recent Behavioral Health Planning and Advisory Council Community Feedback Survey, 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 related to mental health status and access to mental health services. The data allows DMH an opportunity to view Mississippi’s rankings among the other states regarding unmet service needs and gaps within Mississippi’s mental health system.



Mental Health America 2023 – Ranking the States (Mental Health America – 2023) following information is reported on Mississippi’s rankings compared to other states:

- 19th for youth ranking with the highest prevalence of mental illness and lowest rates of access to care.
- 3rd for children with youth with severe Major Depressive Disorder (Mississippi: 8.10%; National: 11.5%)
- 10th for youth with at least one Major Depressive Episode (Mississippi: 15.08%; National: 16.39%)
- 26th for students identified with Emotional Disturbance for an Individualized Education Program (Mississippi 6.88%; National: 7.18%)
- 23rd for children who needed but did not get mental health services (Mississippi: 54.5%; National: 59.8%)
- 43rd for children reporting inadequate insurance (Mississippi: 12.1%-National: 12.3%)
- 42nd in mental health workforce availability with a ratio of 540:1

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 2020 Report, between 2016 – 2019, 27,000 Mississippi adolescents, ages 12 to 17 (11.3% of all adolescents) had at least one Major Depressive Episode (MDE). Statistically, Mississippi’s data is similar the regional average (13.1%), but lower than the national average (14.0 %). Approximately 11,000 adolescents, ages 12- 17, with Major Depressive Episode (41.7% of all adolescents with MDE in Mississippi) received treatment for their depression, which is similar to both the regional average (40.2%) and the national average (41.8%) during the years of 2016-2019. During 2017-2019, the annual average prevalence of past-year SMI experienced by young adults in Mississippi (ages 18-25) was 5.7% (or 18,000), similar to both the regional average of 6.9% and the national average of 7.9% (Behavioral Health Barometer, 2020).

Evidenced by the statistics above, workforce availability in Mississippi is a need for mental health providers serving children and youth. In addition, children with Major Depressive Disorder who did not receive treatment is an identified challenge for Mississippi’s youth. The Division of Children and Youth has promoted mental health awareness by encouraging providers to expand and enhance existing outreach activities throughout the state. In FY23, the Division worked with a private marketing firm, Creative Distillery, to develop brochures, flyers, and public services announcements to promote awareness and sources for treatment for first episode psychosis. Local level MAP Teams receive funds to create and disseminate outreach materials to schools and other child-serving entities across the state to educate the public on available mental health services for children and youth in their communities. Staff from the Mississippi Wraparound Institute and the Division of Children and Youth Services offer presentations at conferences throughout the state on the availability of accessible mental health services through the agencies certified to provide mental health services to children and youth in Mississippi.

Methods to Identify Prevention, Treatment, and Recovery Needs

DMH utilizes the evaluation results and recommendations presented by the Independent Peer Review (IPR) Committee as a general approach to identify, rate, and enhance providers’ treatment needs and capacities. An analysis of the Independent Peer Review reports affords DMH the ability to implement data-driven capacity-building strategies. It allows DMH to pinpoint high-performing agencies with the intent to diffuse their best practices to other agencies throughout the state.

The IPR program assesses the quality, appropriateness, and efficacy of treatment services provided in the state. The intent of this program is to improve treatment services to people with substance use disorders within the state system. Capacity Assessment Instruments utilized by the Independent Peer Review Committee including the following: Dual Diagnosis Capability in Addiction Treatment Index (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment Index (DDCMHT)

DMH has utilized the information gathered through the DDCAT & DDCMHT assessments to: Identify baseline data and program structure to develop the independent peer review program; Develop a map of types of treatment based the agency’s existing co-occurring conditions: Co-Occurring Capable (COC) or Co-Occurring Enhanced (COE); plan and offer targeted workforce training and technical assistance; Assess baseline capacity of MH and SUD programs; and Measure the effectiveness of quality improvement efforts.

The most prevalent prevention services gaps in Mississippi’s Prevention Services are weak social platform host enforcement, rite of passage mindsets/cultures, merchant buy-in, and game day on college and university campuses. Resources necessary to facilitate paradigm shifts pertaining to lack of risk of harm perceptions towards marijuana and alcohol use would help promote education and awareness.

Step 3: Prioritization of State Planning Activities

Table 1 Plan Year FY 2024-2025:

Priority Areas	
1	Community Supports
2	Crisis Services
3	Substance Use Treatment, Prevention, and Recovery Support Services
4	Education, Awareness, and Testing for HIV and IV Drug Users
5	Prevention



Step 4: Objectives, Strategies and Performance Indicators

The primary target populations addressed in the FY 2024-2025 State Plan are children with serious emotional disturbances (SED), adults with serious mental illness (SMI), and youth and adults struggling with substance use disorders.

FY23 Allocated Budget and Projected FY24 SAMHSA Requested Budget Federal Block Grants		
	FY 23	Projected FY 24
Mental Health	\$8,789,930	\$14,209,451
Substance Use	\$14,137,505	\$19,436,489
SOR	\$7,496,336	\$9,532,037
Total	\$ 30,423,771	\$43,177,977

(chrome-extension://efaidnbmnmbpcajpcgclefindmkaj/https://www.samhsa.gov/sites/default/files/samhsa-fy-2024-cj.pdf)

***Note: The following priorities and associated goals are not exclusively funded by federal block grant dollars.**

Priority Area 1	Community Supports
Priority Type	MHS
Population	SMI, SED, ESMI
Goal 1	Maximize the efficiency and effectiveness of community services and supports that prevent unnecessary hospitalizations and utilization of community-based services for children, youth, and adults.
Objective 1	Provide Programs of Assertive Community Treatment (PACT), Intensive Community Outreach and Recovery Teams (ICORT), and Intensive Community Support Services (ICSS) as intensive community Services that are designed to prevent the need for hospitalization
Strategy 1	Monitor readmissions to state psychiatric hospitals and quality utilization of intensive community services: PACT, ICORT, and ICSS
Indicator(s)	<ol style="list-style-type: none"> 1. Unduplicated # of individuals served in PACT 2. PACT readmission rate to state psychiatric hospitals 3. # of new admissions into PACT program 4. Unduplicated # of individuals served in ICORT 5. ICORT readmission rate to state psychiatric hospitals 6. # of new admissions into ICORT program 7. Unduplicated # of individuals served in ICSS 8. ICSS readmission rate to state psychiatric hospitals 9. # of new admissions into ICSS program
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. Unduplicated # of individuals served in PACT <ul style="list-style-type: none"> • In FY22 760 individuals were served 2. PACT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • In FY22 readmission rate was 4% 3. # of new admissions into PACT program

	<ul style="list-style-type: none"> • In FY23 there were 267 admissions into PACT <ol style="list-style-type: none"> 4. Unduplicated # of individuals served in ICORT <ul style="list-style-type: none"> • In FY22 610 individuals were served 5. ICORT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • In FY22 readmission rate was 6% 6. # of new admissions into ICORT program <ul style="list-style-type: none"> • In FY23 there were 320 admissions to ICORT 7. Unduplicated # of individuals served in ICSS <ul style="list-style-type: none"> • In FY22 1054 individuals were served 8. ICSS readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • In FY22 readmission rate was 7.5% 9. # of new admissions into ICSS program <ul style="list-style-type: none"> • In FY23 there were 542 admissions to ICSS
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. Unduplicated # of individuals served in PACT <ul style="list-style-type: none"> • Target in FY24: 775 2. PACT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY24: 4% 3. # of new admissions into PACT program <ul style="list-style-type: none"> • Target in FY24: 270 4. Unduplicated # of individuals served in ICORT <ul style="list-style-type: none"> • Target in FY24: 620 5. ICORT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY24: 6% 6. # of new admissions into ICORT program <ul style="list-style-type: none"> • Target in FY24: 325 7. Unduplicated # of individuals served in ICSS <ul style="list-style-type: none"> • Target in FY24: 1075 8. ICSS readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY24: 7% 9. # of new admissions into ICSS program <ul style="list-style-type: none"> • Target in FY24: 545
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. Unduplicated # of individuals served in PACT <ul style="list-style-type: none"> • Target in FY25: 780 2. PACT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY25: 3% 3. # of new admissions into PACT program <ul style="list-style-type: none"> • Target in FY25: 280 4. Unduplicated # of individuals served in ICORT <ul style="list-style-type: none"> • Target in FY25: 930 5. ICORT readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY25: 5% 6. # of new admissions into ICORT program <ul style="list-style-type: none"> • Target in FY25: 330 7. Unduplicated # of individuals served in ICSS <ul style="list-style-type: none"> • Target in FY25: 1080 8. ICSS readmission rate to state psychiatric hospitals <ul style="list-style-type: none"> • Target in FY25: 6% 9. # of new admissions into ICSS program <ul style="list-style-type: none"> • Target in FY25: 550

Objective 2	Provide services that support a person's continued recovery in the community
Strategy 2.1	Monitor utilization of Supported Employment programs
Indicator(s)	<ol style="list-style-type: none"> 1. # of individuals employed through IPS Supported Employment Programs 2. # of individuals employed through VR (Expansion) Supported Employment Programs 3. # of referrals to MDRS
Baseline Measurement	<ol style="list-style-type: none"> 1. # of individuals employed through IPS Supported Employment Programs <ul style="list-style-type: none"> • In FY 22, 136 individuals were employed 2. # of individuals employed through VR (Expansion) Supported Employment Programs <ul style="list-style-type: none"> • In FY 22, 83 individuals were employed 3. # of Referrals to MDRS <ul style="list-style-type: none"> • In FY22, there were 272 individuals referred to MDRS
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of individuals employed through IPS Supported Employment Programs <ul style="list-style-type: none"> • Target FY24: 145 individuals were employed 2. # of individuals employed through VR (Expansion) Supported Employment Programs <ul style="list-style-type: none"> • Target FY24: 95 individuals were employed 3. # of Referrals to MDRS <ul style="list-style-type: none"> • Target FY24: 290 individuals referred to MDRS
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of individuals employed through IPS Supported Employment Programs <ul style="list-style-type: none"> • Target FY25: 150 individuals were employed 2. # of individuals employed through VR (Expansion) Supported Employment Programs <ul style="list-style-type: none"> • Target FY25: 110 individuals were employed 3. # of Referrals to MDRS <ul style="list-style-type: none"> • Target FY25: 310 individuals referred to MDRS
Strategy 2.2	Monitor the readmission rate to state psychiatric hospitals of people served through CHOICE housing program, Supervised Living, and Supported Living
Indicator(s)	<ol style="list-style-type: none"> 1. CHOICE # served 2. CHOICE housing program readmission rate 3. # of Mississippi Affirmative Olmstead Initiative (MAOI) units available 4. Supervised and Supported Living # served 5. Supervised and Supported Living readmission rate
Baseline Measurement	<ol style="list-style-type: none"> 1. CHOICE # served <ul style="list-style-type: none"> • In FY22, 239 individuals were served through CHOICE 2. CHOICE housing program readmission rate <ul style="list-style-type: none"> • In FY22, 0.8% (2) of individuals in CHOICE housing were admitted to a state psychiatric hospital 3. # of Mississippi Affirmative Olmstead Initiative (MAOI) units available <ul style="list-style-type: none"> • In FY23, >400 tax credit housing units for individuals with SMI 4. Supervised and Supported Living # served <ul style="list-style-type: none"> • In FY22, 283 individuals were served by Supported and

	<p>Supervised Living</p> <p>5. Supervised and Supported Living readmission rate</p> <ul style="list-style-type: none"> • In FY22, 0.7% (2) of individuals in Supported and Supervised Living were admitted to a state psychiatric hospital
First Year Target/Outcome Measurement	<p>1. CHOICE # served</p> <ul style="list-style-type: none"> • Target FY24: 245 individuals were served through CHOICE <p>2. CHOICE housing program readmission rate</p> <ul style="list-style-type: none"> • Target FY24: <1% <p>3. # of Mississippi Affirmative Olmstead Initiative (MAOI) units available</p> <ul style="list-style-type: none"> • Target FY24: maintain >400 tax credit housing units for individuals with SMI <p>4. Supervised and Supported Living # served</p> <ul style="list-style-type: none"> • Target FY24: 290 individuals were served by Supported and Supervised Living <p>5. Supervised and Supported Living readmission rate</p> <ul style="list-style-type: none"> • Target FY24: <1%
Second Year Target/Outcome Measurement	<p>1. CHOICE # served</p> <ul style="list-style-type: none"> • Target FY24: 250 individuals were served through CHOICE <p>2. CHOICE housing program readmission rate</p> <ul style="list-style-type: none"> • Target FY25: <0.5% <p>3. # of Mississippi Affirmative Olmstead Initiative (MAOI) units available</p> <ul style="list-style-type: none"> • Target FY25: increase # of tax credit housing units by 10% <p>4. Supervised and Supported Living # served</p> <ul style="list-style-type: none"> • Target FY25: 300 individuals were served by Supported and Supervised Living <p>5. Supervised and Supported Living readmission rate</p> <ul style="list-style-type: none"> • Target FY25: <0.5%
Strategy 2.3	Continue to provide funding to defray mental health treatment costs through Purchase of Service grants to CMHCs for individuals underinsured and without a payor source
Indicator(s)	1. # of units of service
Baseline Measurement	<p>1. # of units of service</p> <ul style="list-style-type: none"> • In FY23, 20, 828 units of service were provided to adults with SMI
First Year Target/Outcome Measurement	<p>1. # of units of service</p> <ul style="list-style-type: none"> • Target FY24: > 21, 000 units of service were provided to adults with SMI
Second Year Target/Outcome Measurement	<p>1. # of units of service</p> <ul style="list-style-type: none"> • Target FY25: >22, 000 units of service were provided to adults with SMI
Strategy 2.4	In an effort to maintain high quality services and assess access to care, fidelity monitoring visits will occur regularly for PACT, ICORT, Supported Employment, and ICSS
Indicator(s)	1. Evidence-based and standard-based fidelity scoring on each respective adult community mental health fidelity monitored service
Baseline Measurement	1. Evidence-based and standard-based fidelity scoring on each respective adult community mental health fidelity monitored service

	<ul style="list-style-type: none"> Staff training and first year of comprehensive fidelity assessments were conducted in FY23
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> Evidence-based and standard-based fidelity scoring on each respective adult community mental health fidelity monitored service <ul style="list-style-type: none"> Target FY24: Fidelity scores for all fidelity monitored adult community mental health services will be maintained at least fair fidelity with appropriate technical assistance and corrective plans addressed
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> Evidence-based and standard-based fidelity scoring on each respective adult community mental health fidelity monitored service <ul style="list-style-type: none"> Target FY25: Fidelity scores for all fidelity monitored adult community mental health services will be maintained at least fair fidelity with appropriate technical assistance and corrective plans addressed
Objective 3	Provide community supports for children and youth with serious emotional disturbance and prevent the need for out-of-home placements
Strategy 3.1	Utilize MAP teams to prevent unnecessary institutionalizations among children and youth
Indicator(s)	<ol style="list-style-type: none"> # of youth served by MAP teams % of youth needing a higher level of care
Baseline Measurement	<ol style="list-style-type: none"> # of youth served by MAP teams <ul style="list-style-type: none"> In FY22, 778 youth were served by MAP Teams % of youth needing a higher level of care <ul style="list-style-type: none"> This is a new indicator. Baseline data will be collected in FY 2024
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> # of youth served by MAP teams <ul style="list-style-type: none"> Target FY24: 815 youth were served by MAP Teams % of youth needing a higher level of care <p>This is a new indicator. Baseline data will be collected in FY 2024</p>
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> # of youth served by MAP teams <ul style="list-style-type: none"> In FY25, 825 youth were served by MAP Teams % of youth needing a higher level of care <ul style="list-style-type: none"> Target FY25: <8% of youth requiring higher level of care
Strategy 3.2	Increase utilization of Wraparound Facilitation/Supportive Aftercare processes with children and youth
Indicator(s)	<ol style="list-style-type: none"> # of youth served by Wraparound Facilitation/Supportive Aftercare % of youth who took part in Wraparound Facilitation/Supportive Aftercare as an alternative to more restrictive placement % of youth involved in Wraparound Facilitation/Supportive Aftercare that required a higher level of care
Baseline Measurement	<ol style="list-style-type: none"> # of youth served by Wraparound Facilitation/Supportive Aftercare <ul style="list-style-type: none"> In FY22, 1,887 youth participated in Wraparound Facilitation % of youth who took part in Wraparound Facilitation/Supportive Aftercare as an alternative to more restrictive placement <ul style="list-style-type: none"> In FY22, 26% of youth participated in Wraparound Facilitation/Supportive Aftercare as an alternative to more restrictive placement % of youth involved in Wraparound Facilitation/Supportive Aftercare that required a higher level of care <ul style="list-style-type: none"> This is a new indicator. Baseline data will be collected in FY 2024
First Year Target/Outcome	<ol style="list-style-type: none"> # of youth served by Wraparound Facilitation/Supportive Aftercare

Measurement	<ul style="list-style-type: none"> • Target FY24: 1,900 youth participated in Wraparound Facilitation <ol style="list-style-type: none"> 2. % of youth who took part in Wraparound Facilitation/Supportive Aftercare as an alternative to more restrictive placement <ul style="list-style-type: none"> • Target FY24: 28% 3. % of youth involved in Wraparound Facilitation/Supportive Aftercare that required a higher level of care <ul style="list-style-type: none"> • This is a new indicator. Baseline data will be collected in FY 2024
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth served by Wraparound Facilitation/Supportive Aftercare <ul style="list-style-type: none"> • Target FY25: 1,925 youth participated in Wraparound Facilitation 2. % of youth who took part in Wraparound Facilitation/Supportive Aftercare as an alternative to more restrictive placement <ul style="list-style-type: none"> • Target FY25: 30% 3. % of youth involved in Wraparound Facilitation/Supportive Aftercare that required a higher level of care <ul style="list-style-type: none"> • Target FY25 will be based on FY24 data
Strategy 3.3	Utilize NAVIGATE programs to assist youth and young adults experiencing first episode psychosis, including efforts to function well at home, on the job, at school and in the community through the Coordinated Specialty Care Team
Indicator(s)	<ol style="list-style-type: none"> 1. # of youth and young adults served by NAVIGATE 2. % of individuals maintained in their homes and communities
Baseline Measurement	<ol style="list-style-type: none"> 1. # of youth and young adults served by NAVIGATE <ul style="list-style-type: none"> • In FY22, 83 youth and young adults were served 2. % of individuals maintained in their homes and communities <ul style="list-style-type: none"> • This is a new indicator. Baseline data will be collected in FY 2024
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth and young adults served by NAVIGATE <ul style="list-style-type: none"> • Target FY24: 100 youth and young adults served 2. % of individuals maintained in their homes and communities <ul style="list-style-type: none"> • This is a new indicator. Baseline data will be collected in FY 2024
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth and young adults served by NAVIGATE <ul style="list-style-type: none"> • Target FY25: 125 youth and young adults served 2. % of individuals maintained in their homes and communities <ul style="list-style-type: none"> • Target FY25 will be based on FY24 data
Strategy 3.4	Provide services for juvenile offenders that aid in the successful transition from a detention center to their communities and in preventing recidivism in the juvenile justice system
Indicator(s)	<ol style="list-style-type: none"> 1. # of youth served in JOP 2. % of youth in JOP that re-enter the detention center following participation in the JOP 3. # of youth referred to Adolescent Offender Programs (AOP) as an alternative to incarceration 4. # of youth completing the AOP with no reoffending behaviors 5. # of youth completing the AOP with reoffending behaviors
Baseline Measurement	<ol style="list-style-type: none"> 1. # of youth served in JOP <ul style="list-style-type: none"> • In FY23, 2150 youth were served in the JOP program 2. % of youth in JOP that re-enter the detention center following participation in the JOP <ul style="list-style-type: none"> • In FY23, 700 reentered the JDC due to reoffending behavior 3. # of youth referred to Adolescent Offender Programs (AOP) as an alternative to incarceration <ul style="list-style-type: none"> • AOP is a new service being offered in FY24

	<ol style="list-style-type: none"> 4. # of youth completing the AOP with no reoffending behaviors <ul style="list-style-type: none"> • AOP is a new service being offered in FY24 5. # of youth completing the AOP with reoffending behaviors <ul style="list-style-type: none"> • AOP is a new service being offered in FY24
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth served in JOP <ul style="list-style-type: none"> • Target FY24: 2200 youth were served in the JOP program 2. % of youth in JOP that re-enter the detention center following participation in the JOP <ul style="list-style-type: none"> • Target FY24: <700 reentered the JDC due to reoffending behavior 3. # of youth referred to Adolescent Offender Programs (AOP) as an alternative to incarceration <ul style="list-style-type: none"> • AOP is a new service being offered in FY24 4. # of youth completing the AOP with no reoffending behaviors <ul style="list-style-type: none"> • AOP is a new service being offered in FY24 5. # of youth completing the AOP with reoffending behaviors <ul style="list-style-type: none"> • AOP is a new service being offered in FY24
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth served in JOP <ul style="list-style-type: none"> • Target FY25: 2250 youth were served in the JOP program 2. % of youth in JOP that re-enter the detention center following participation in the JOP <ul style="list-style-type: none"> • Target FY25: <650 reentered the JDC due to reoffending behavior 3. # of youth referred to Adolescent Offender Programs (AOP) as an alternative to incarceration <ul style="list-style-type: none"> • Target FY25 will be based on FY24 data 4. # of youth completing the AOP with no reoffending behaviors <ul style="list-style-type: none"> • Target FY25 will be based on FY24 data 5. # of youth completing the AOP with reoffending behaviors <ul style="list-style-type: none"> • Target FY25 will be based on FY24 data
Strategy 3.5	Utilize Intensive Community Support Services to maintain children and youth in their communities without the need for inpatient hospitalization
Indicator(s)	<ol style="list-style-type: none"> 1. # of youth referred from acute and/or residential treatment to ICSS 2. # of youth maintained in the community with supports from the ICSS programs 3. # of youth readmitted to acute and/or residential treatment from the ICSS program
Baseline Measurement	<ol style="list-style-type: none"> 1. # of youth referred from acute and/or residential treatment to ICSS <ul style="list-style-type: none"> • ICSS for children and youth was expanded in FY23; however, due to significant workforce limitations many CMHCs had difficulty hiring for the role. Baseline data will be obtained for this indicator in FY24. 2. # of youth maintained in the community with supports from the ICSS programs <ul style="list-style-type: none"> • In FY22, there was one CMHC with an employed ICSS for children and youth. Thirty-three (33) children and youth with SED were served. 3. # of youth readmitted to acute and/or residential treatment from the ICSS program <ul style="list-style-type: none"> • ICSS for children and youth was expanded in FY23; however, due to significant workforce limitations many CMHCs had difficulty hiring for the role. Baseline data will be obtained for this indicator in FY24.

First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth referred from acute and/or residential treatment to ICSS <ul style="list-style-type: none"> • ICSS for children and youth was expanded in FY23; however, due to significant workforce limitations many CMHCs had difficulty hiring for the role. Baseline data will be obtained for this indicator in FY24. 2. # of youth maintained in the community with supports from the ICSS programs <ul style="list-style-type: none"> • Target FY24: 40 children and youth with SED served 3. # of youth readmitted to acute and/or residential treatment from the ICSS program <ul style="list-style-type: none"> • ICSS for children and youth was expanded in FY23; however, due to significant workforce limitations many CMHCs had difficulty hiring for the role. Baseline data will be obtained for this indicator in FY24.
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of youth referred from acute and/or residential treatment to ICSS <ul style="list-style-type: none"> • Target FY25: target will be based on FY24 data 2. # of youth maintained in the community with supports from the ICSS programs <ul style="list-style-type: none"> • Target FY25: 50 children and youth with SED served 3. # of youth readmitted to acute and/or residential treatment from the ICSS program <ul style="list-style-type: none"> • Target FY25: target will be based on FY24 data
Description of Data/Data Source	Monthly submission and quarterly reviews of data submitted to the Bureau of Behavioral Health Services through monthly reporting metrics and crosswalked data from certified providers electronic health record (EHR) systems to the centralized data repository with the MS Department of Mental Health, InfoBridge (Data Warehouse) and WITS.

Priority Area 2	Crisis Services
Priority Type	BHCS
Population	SMI, SED, ESMI, BHCS, SUD
Goal 1	To improve connections and the effectiveness of the crisis continuum network of services statewide
Objective 1	Increase utilization of Community Based Crisis Services to divert people from a higher level of care
Strategy 1.1	Monitor utilization of Crisis Stabilization Units
Indicator(s)	<ol style="list-style-type: none"> 1. # of admissions to CSU 2. % of individuals diverted from a state psychiatric hospital
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of admissions to CSU <ul style="list-style-type: none"> • In FY22, 184 CSU beds were funded with 3,108 admissions 2. % of individuals diverted from a state psychiatric hospital <ul style="list-style-type: none"> • In FY22, 90.94% were diverted from state psychiatric hospitals
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of admissions to CSU <ul style="list-style-type: none"> • Target FY24: >3,125 admissions 2. % of individuals diverted from a state psychiatric hospital <ul style="list-style-type: none"> • Target FY24: >90% diversion rate
Second Year Target/Outcome	<ol style="list-style-type: none"> 1. # of admissions to CSU <ul style="list-style-type: none"> • Target FY25: >3,150 admissions

Measurement	2. % of individuals diverted from a state psychiatric hospital • Target FY25: >91% diversion rate
Strategy 1.2	Implementation of Court Liaisons throughout the state dedicated to assist individuals and families considering court commitment and provide awareness and access to services that prevent unnecessary hospitalization
Indicator(s)	1. # of referrals from Chancery Court 2. # of individuals served by Court Liaison 3. # Number of people diverted from placement under a writ or involuntary commitment process
Baseline Measurement(s)	1. # of referrals from Chancery Court • In FY23, 997 referrals were received 2. # of individuals served by Court Liaison • In FY23, 1,363 were served 3. # Number of people diverted from placement under a writ or involuntary commitment process • In FY23, 880 were diverted
First Year Target/Outcome Measurement	1. # of referrals from Chancery Court • Target FY24: 1010 2. # of individuals served by Court Liaison • Target FY24: 1400 3. # Number of people diverted from placement under a writ or involuntary commitment process • Target FY24: 900
Second Year Target/Outcome Measurement	1. # of referrals from Chancery Court • Target FY24: 1025 2. # of individuals served by Court Liaison • Target FY24: 1500 3. # Number of people diverted from placement under a writ or involuntary commitment process • Target FY24: 925
Strategy 1.3	Provide and attend trainings in evidence-based and best practices to a variety of stakeholders
Indicator(s)	• # of CIT officers trained • # of YMHFA trainings • # of trainings and workshops provided through National Alliance on Mental Illness of Mississippi (NAMI-MS) • # of strength-based, person-centered, recovery-oriented trainings and awareness campaigns for individuals, families, and providers • # of cultural competency trainings for staff within the state's mental health system to focus on disproportionate trauma and discrimination • # of Technical Assistance requested and learning collaboratives attended on workforce shortages • # of Technical Assistance requested and learning collaboratives attended on peer support services
Baseline Measurement(s)	1. # of CIT officers trained • In FY23, 170 officers were trained in Crisis Intervention Team Training 2. # of YMHFA trainings • In FY23, 6 trainings were offered to parents and school personnel 3. # of trainings and workshops provided through National Alliance on Mental Illness of Mississippi (NAMI-MS) • In FY23, 47 workshops/trainings were offered

	<ol style="list-style-type: none"> 4. Request Technical Assistance and apply for available learning collaboratives on workforce shortages in FY24 5. Request Technical Assistance and apply for available learning collaboratives on peer support services in FY24
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of CIT officers trained <ul style="list-style-type: none"> • Target FY24: 190 officers 2. # of YMHA trainings <ul style="list-style-type: none"> • Target FY24: 10 trainings 3. # of NAMI trainings <ul style="list-style-type: none"> • Target FY24: 50 workshops/trainings 4. Request Technical Assistance and apply for available learning collaboratives on workforce shortages in FY24 5. Request Technical Assistance and apply for available learning collaboratives on peer support services in FY24
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of CIT officers trained <ul style="list-style-type: none"> • Target FY25: 200 officers 2. # of YMHA trainings <ul style="list-style-type: none"> • Target FY25: 200 trainings 3. # of NAMI trainings <ul style="list-style-type: none"> • Target FY25: 55 workshops/trainings 4. Request Technical Assistance and apply for available learning collaboratives on workforce shortages <ul style="list-style-type: none"> • Request at least 1 TA and apply for at least 1 learning collaborative 5. Request Technical Assistance and apply for available learning collaboratives on peer support services <ul style="list-style-type: none"> • Request at least 1 TA and apply for at least 1 learning collaborative
Objective 2	Expand capacity of 988 Lifeline Centers within the Crisis Continuum and increase the effectiveness of Mobile Crisis Emergency Response Teams (MCerT) to divert people from a higher level of care
Strategy 2	Monitor utilization of MCerT
Indicator(s)	<ol style="list-style-type: none"> 1. # of MCerT Contacts 2. # of MCerT deployments 3. # of 988 Calls
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of MCerT Contacts <ul style="list-style-type: none"> • In FY23, there were 9,658 MCerT Contacts 2. # of MCerT deployments <ul style="list-style-type: none"> • In FY23, there were 1,970 deployments 3. # of 988 Calls <ul style="list-style-type: none"> • In FY23, there were 14,222 988 Calls
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of MCerT Contacts <ul style="list-style-type: none"> • Target FY24: >9,700 MCerT Contacts 2. # of MCerT deployments <ul style="list-style-type: none"> • Target FY24: >1970 deployments 3. # of 988 Calls <ul style="list-style-type: none"> • Target FY24: >14,225 Calls
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of MCerT Contacts <ul style="list-style-type: none"> • Target FY25: >9,725 MCerT Contacts 2. # of MCerT deployments <ul style="list-style-type: none"> • Target FY25: >1985 deployments 3. # of 988 Calls

	<ul style="list-style-type: none"> Target FY25: >14,275 Calls
Description of Data/Data Source	<p>Monthly submission and quarterly reviews of data submitted to the Bureau of Behavioral Health Services through monthly reporting metrics and crosswalked data from certified providers electronic health record (EHR) systems to the centralized data repository with the MS Department of Mental Health, InfoBridge (Data Warehouse) and WITS.</p> <p>The Mobile Crisis Response Teams began entering data in the WITS Crisis Module beginning April 2023 988 Lifeline Centers also track the number of calls and contacts.</p> <p>Training data is collected by the Bureau of Outreach and Planning which oversees all outreach efforts.</p>

Priority Area 3	Substance Use Treatment, Prevention, and Recovery Support Services
Priority Type	SUD
Population	SUD, SMI, SED, PPWDC, PWID, HIV/TB,
Goal 1	Maximize the efficiency and effectiveness of community-based substance use services and supports
Objective 1	Provide an array of substance use disorder treatment, prevention, and recovery support services
Strategy 1.1	Provide community residential services for people in need of substance use disorder treatment
Indicator(s)	<ol style="list-style-type: none"> # of people served in high-intensity residential treatment # of people served in low-intensity residential treatment # of community-based beds available for residential treatment
Baseline Measurement(s)	<ol style="list-style-type: none"> # of people served in high-intensity residential treatment <ul style="list-style-type: none"> In FY22, 3,765 adults were served # of people served in low-intensity residential treatment <ul style="list-style-type: none"> In FY22, 509 adults were served # of community-based beds available for residential treatment <ul style="list-style-type: none"> In FY22, there were 646 community certified beds for substance use residential services
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> # of people served in high-intensity residential treatment <ul style="list-style-type: none"> Target FY24: increase by 10% # of people served in low-intensity residential treatment <ul style="list-style-type: none"> Target FY24: increase by 10% # of community-based beds available for residential treatment <ul style="list-style-type: none"> Target FY24: increase # of beds by 2%
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> # of people served in high-intensity residential treatment <ul style="list-style-type: none"> Target FY25: increase by 5% # of people served in low-intensity residential treatment <ul style="list-style-type: none"> Target FY25: increase by 5% # of community-based beds available for residential treatment <ul style="list-style-type: none"> Target FY25: increase # of beds by 2%
Strategy 1.2	Utilize the Peer Bridger program to connect people discharged from DMH behavioral health programs with their local Community Mental Health Centers
Indicator(s)	<ol style="list-style-type: none"> # of trained Peer Bridgers employed within the state mental health system

	2. # of individuals served through bridging meetings at behavioral health programs and CSUs
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of trained Peer Bridgers employed within the state mental health system <ul style="list-style-type: none"> • In FY23, there were 25 employed Peer Bridgers 2. # of individuals served through bridging meetings at behavioral health programs and CSUs <ul style="list-style-type: none"> • In FY23, 970 individuals participated in bridging meetings
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of trained Peer Bridgers employed within the state mental health system <ul style="list-style-type: none"> • Target FY24: increase # of employed Peer Bridgers by 10% 2. # of individuals served through bridging meetings at behavioral health programs and CSUs <ul style="list-style-type: none"> • Target FY24: increase # of individuals served through bridging meetings by 10%
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of trained Peer Bridgers employed within the state mental health system <ul style="list-style-type: none"> • Target FY25: increase # of employed Peer Bridgers by 10% 2. # of individuals served through bridging meetings at behavioral health programs and CSUs <ul style="list-style-type: none"> • Target FY25: increase # of individuals served through bridging meetings by 10%
Strategy 1.3	Utilize people with lived experience of mental illness and/or substance use and/or parent/caregivers to provide varying supports as Certified Peer Support Specialists (CPSSs) to assist others in their journey to recovery and resiliency
Indicator(s)	1. # of trained CPSSs employed by DMH certified providers
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of trained CPSSs employed by DMH certified providers <ul style="list-style-type: none"> • In FY23, 197 CPSSs were employed by DMH certified providers
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of trained CPSSs employed by DMH certified providers <ul style="list-style-type: none"> • Target FY24: increase # of CPSSs employed by DMH certified providers by at least 3%
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of trained CPSSs employed by DMH certified providers <ul style="list-style-type: none"> • Target FY25: increase # of CPSSs employed by DMH certified providers by at least 3%
Strategy 1.4	Conduct Personal Outcome Measures (POM) interviews to measure outcomes of people receiving mental health services. DMH will offer technical assistance to providers after POM reports are released to the mental health service providers if needed.
Indicator(s)	2. # of visits to conduct POM interviews at CMHCs
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of visits to conduct POM interviews at CMHCs <ul style="list-style-type: none"> • In FY23, 9 POM interview visits were conducted
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of visits to conduct POM interviews at CMHCs <ul style="list-style-type: none"> • Target FY24, at least 9 POM interview visits
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of visits to conduct POM interviews at CMHCs <ul style="list-style-type: none"> • Target FY25, at least 9 POM interview visits

Strategy 1.5	Strengthen the utilization of Wellness Recovery Action Plans (WRAPs) in the mental health system to help people identify and understand their personal wellness resources.
Indicator(s)	1. # of Wellness Action Recovery Plans begun prior to discharge from behavioral health programs and CSUs
Baseline Measurement(s)	1. # of Wellness Action Recovery Plans begun prior to discharge from behavioral health programs and CSUs <ul style="list-style-type: none"> • In FY23, 970 WRAPs were begun prior to discharge
First Year Target/Outcome Measurement	1. # of Wellness Action Recovery Plans begun prior to discharge from behavioral health programs and CSUs <ul style="list-style-type: none"> • Target FY24: 1000 WRAPs begun prior to discharge
Second Year Target/Outcome Measurement	1. # of Wellness Action Recovery Plans begun prior to discharge from behavioral health programs and CSUs <ul style="list-style-type: none"> • Target FY25: 1030 WRAPs begun prior to discharge
Strategy 1.6	Delivery of quality specialized services to pregnant women and women with dependent children.
Indicator(s)	1. The percentage of pregnant women served that successfully completed treatment 2. The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete treatment. 3. # of Residential beds capacity in the state for PPWDC
Baseline Measurement(s)	1. The percentage of pregnant women served that successfully completed treatment <ul style="list-style-type: none"> • Implemented in January 2018 with improved data metrics planned for FY24. In FY22, 107 pregnant women served 2. The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete treatment. <ul style="list-style-type: none"> • Implemented in January 2018 with improved data metrics planned for FY24. In FY 22, 8 pregnant women received MAT. 3. # of Residential beds capacity in the state for PPWDC <ul style="list-style-type: none"> • In FY23, 76 bed-capacity
First Year Target/Outcome Measurement	1. The percentage of women served that successfully completed treatment <ul style="list-style-type: none"> • Implemented in January 2018 with improved data metrics planned for FY24. 2. The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete treatment. <ul style="list-style-type: none"> • Implemented in January 2018 with improved data metrics planned for FY24. 3. # of Residential beds capacity in the state for PPWDC <ul style="list-style-type: none"> • Target FY24: 84 bed-capacity
Second Year Target/Outcome Measurement	1. The percentage of women served that successfully completed treatment <ul style="list-style-type: none"> • Target FY25: 3% increase in # of pregnant women who successfully completed treatment during 2023-2024. 2. The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete

	<p>treatment.</p> <ul style="list-style-type: none"> • Target FY25: 25% increase in the # of pregnant women that have access to MAT during FY25 <p>3. # of Residential beds capacity in the state for PPWDC</p> <ul style="list-style-type: none"> • Target FY25: consistently maintain 84 bed-capacity
Objective 2	Strengthen the co-occurring conditions and capacities of all DMH certified Community Mental Health Centers (CMHCs), Standalone Providers, and Pregnant and Parenting Providers by ensuring the implementation of Level of Care Placement Assessments in accordance with The ASAM Criteria.
Strategy 2.1	Determine the co-occurring level of the Community Mental Health Centers (CMHCs) by way of a DDCMHT assessment. (Co-occurring Level will either be Co-Occurring Capable or Co-Occurring Enhanced)
Indicator(s)	<ol style="list-style-type: none"> 1. Co-Occurring Level assignment for each treatment provider based on DDCMHT assessment 2. Fidelity Assessment Score
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. Co-Occurring Level assignment for each treatment provider based on DDCMHT assessment <ul style="list-style-type: none"> • In FY22, 5% of CMHCs were re-assessed for their respective Co-Occurring Level assignment 2. SUBG Fidelity Assessment <ul style="list-style-type: none"> • In FY23, SUBG Fidelity Assessments were re-initiated
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. Co-Occurring Level assignment for each treatment provider based on DDCMHT assessment <ul style="list-style-type: none"> • Target FY24: An additional 10% of SUD treatment providers will be assessed annually 2. SUBG Fidelity Assessment <ul style="list-style-type: none"> • Target FY24: At least 30% of SUD Programs will have a Fidelity Visit by end of FY.
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. Co-Occurring Level assignment for each treatment provider based on DDCMHT assessment <ul style="list-style-type: none"> • Target FY25: An additional 10% of SUD treatment providers will be assessed annually 2. SUBG Fidelity Assessment <ul style="list-style-type: none"> • Target FY25: At least 30% of SUD Programs will have a Fidelity Visit by end of FY.
Description of Data/Data Source	<p>Monthly submission and quarterly reviews of data submitted to the Bureau of Behavioral Health Services through monthly reporting metrics and crosswalked data from certified providers electronic health record (EHR) systems to the centralized data repository with the MS Department of Mental Health, InfoBridge (Data Warehouse) and WITS.</p> <p>Data is maintained by DMH based on submission of Verification of Employment forms to the DMH Division of Place and Division of Peer Recovery and Support.</p> <p>Written Report of Findings; DDCMHT Scoring Results Annual Performance; Annual SUBG Fidelity Monitoring Visits</p>

Priority Area 4	Education, Awareness, and Testing for HIV and IV Drug Users
Priority Type	SUD
Population	SUD, EIS, HIV/TB, PWWDC, PWID
Goal 1	Increase access to awareness campaigns, educational materials and services, and testing
Objective 1	Provide each substance use disorder treatment centers with current HIV materials and accessible educational resources
Strategy 1.1	Provide community residential services for people in need of substance use disorder treatment
Indicator(s)	<ol style="list-style-type: none"> 1. # of individuals determined to be at high risk for HIV who have access to HIV Rapid Testing and education Services 2. # of individuals receiving substance use disorder services receiving best practices for HIV care 3. # of IV drug users who successfully completed treatment.
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. # of individuals determined to be at high risk for HIV who have access to HIV Rapid Testing and education Services <ul style="list-style-type: none"> • Baseline metrics will be aggregated for FY23 2. # of individuals receiving substance use disorder services receiving best practices for HIV care <ul style="list-style-type: none"> • Baseline metrics will be aggregated for FY23 3. # of IV drug users who successfully completed treatment. <ul style="list-style-type: none"> • In FY22, 1091 non-pregnant IV drug users and 22 pregnant drug users (1,113) participated in treatment.
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of individuals determined to be at high risk for HIV who have access to HIV Rapid Testing and Education Services <ul style="list-style-type: none"> • Target FY24: increase by 1% # of individuals who have access to HIV Rapid Testing and Education Services who are identified as high risk 2. # of individuals receiving substance use disorder services receiving best practices for HIV care <ul style="list-style-type: none"> • Target FY24: At least 40% of individuals receiving substance use disorder services will receive educational materials informing best practices for HIV care 3. # of IV drug users who successfully completed treatment. <ul style="list-style-type: none"> • Target FY24: increase by 1% # of IV drug users who successfully complete treatment
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. # of individuals determined to be at high risk for HIV who have access to HIV Rapid Testing and Education Services <ul style="list-style-type: none"> • Target FY25: increase by 2% # of individuals who have access to HIV Rapid Testing and Education Services who are identified as high risk 2. # of individuals receiving substance use disorder services receiving best practices for HIV care <ul style="list-style-type: none"> • Target FY25: At least 50% of individuals receiving substance use disorder services will receive educational materials informing best practices for HIV care 3. # of IV drug users who successfully completed treatment. <ul style="list-style-type: none"> • Target FY25: increase by 2% # of IV drug users who successfully complete treatment
Description of Data/Data	In accordance to the Grant Agreement established between the DMH and the Mississippi Department of Health (MSDH), the MSDH will

Source	<p>oversee data collection regarding HIV services. MSDH will collect and report HIV data to the DMH annually or upon request. Bureau of Behavioral Health Services will continue to conduct monitoring visits to ensure the completion of this goal. During these monitoring visits individual's records at the 11 community mental health centers will be monitored routinely for documentation of these activities on the DMH Educational/Assessment Forms. Programs will also annually submit a SUBG progress report to Mississippi Department of Mental health reporting progress on each of the block grant goals.</p> <p>Treatment episode data sets will be available for review in Data Warehouse and WITS to determine the number of IV drug users who successfully complete treatment each year.</p>
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Priority Area 5	Prevention
Priority Type	SUD
Population	SUD, EIS, HIV/TB, PWWDC, PWID
Goal 1	Increase and maintain prevention and education-based efforts regarding substance use
Objective 1	Increase recovery-oriented approaches, decrease substance use and increase awareness
Strategy 1.1	Develop and maintain relationships with substance use providers, community stakeholders, and school districts throughout the state
Indicator(s)	<ol style="list-style-type: none"> 1. % of adolescents with prescription drug use (past 30 days) 2. % of adolescents reporting non-medical use of prescription drugs 3. % of adolescents reporting alcohol use (past 30 days) 4. % of adolescents reporting marijuana use (past 30 days) 5. # of Narcan doses distributed
Baseline Measurement(s)	<ol style="list-style-type: none"> 1. % of adolescents with illicit drug use (past 30 days) <ul style="list-style-type: none"> • Based on 2019 National Survey on Drug Use and Health and the National Survey of Substance Use Treatment Services, 6.6% of 12-17 year olds reported illicit drug use 2. % of adolescents reporting non-medical use of prescription drugs <ul style="list-style-type: none"> • Based on 2019 National Survey on Drug Use and Health and the National Survey of Substance Use Treatment Services, 3.9% of 12-year-olds and older reported non-medical use of prescription drugs 3. % of adolescents reporting alcohol use (past 30 days) <ul style="list-style-type: none"> • Based on 2019 National Survey on Drug Use and Health and the National Survey of Substance Use Treatment Services, 9.3% of 12-17 year olds reported alcohol use 4. % of adolescents reporting marijuana use (past 30 days) <ul style="list-style-type: none"> • Based on 2019 National Survey on Drug Use and Health and the National Survey of Substance Use Treatment Services, 5% of 12-17 year olds reported marijuana use 5. # of Narcan doses distributed <ul style="list-style-type: none"> • In FY22, 9,760 doses of Narcan distributed
First Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. % of adolescents with illicit drug use (past 30 days) <ul style="list-style-type: none"> • Target FY24: < 6.2% 2. % of adolescents reporting non-medical use of prescription drugs <ul style="list-style-type: none"> • Target FY24: < 3.5% 3. % of adolescents reporting alcohol use (past 30 days)

	<ul style="list-style-type: none"> • Target FY24: <9.0% 4. % of adolescents reporting marijuana use (past 30 days) • Target FY24: <4.5% 5. # of Narcan doses distributed • Target FY24: >10,000 doses of Narcan distributed
Second Year Target/Outcome Measurement	<ol style="list-style-type: none"> 1. % of adolescents with illicit drug use (past 30 days) • Target FY25: < 6.0% 2. % of adolescents reporting non-medical use of prescription drugs • Target FY25: < 3.2% 3. % of adolescents reporting alcohol use (past 30 days) • Target FY25: <8.5% 4. % of adolescents reporting marijuana use (past 30 days) • Target FY25: <4.2% 5. # of Narcan doses distributed • Target FY25: >10,500 doses of Narcan distributed
Description of Data/Data Source	<p>In accordance to the Grant Agreement established between the DMH and the Mississippi Department of Health (MSDH), the MSDH will oversee data collection regarding HIV services. MSDH will collect and report HIV data to the DMH annually or upon request. Bureau of Behavioral Health Services will continue to conduct monitoring visits to ensure the completion of this goal. During these monitoring visits individual's records at the 11 community mental health centers will be monitored routinely for documentation of these activities on the DMH Educational/Assessment Forms. Programs will also annually submit a SUBG progress report to Mississippi Department of Mental health reporting progress on each of the block grant goals.</p> <p>Smarttrack Description: The MS Department of Mental Health (DMH), Bureau of Behavioral Health Services began collaborating with the MS Department of Education, Office of Healthy Schools in 2001 to implement a statewide youth survey (SmartTrack) that measures youth consumption and consequence patterns of alcohol and drug use in MS. It also measures other risk and protective factors including drug-related disapproval attitudes and perceived risk of harm, suicide ideation and attempts, health, nutrition, family influences, school safety and bullying, and social engagement.</p>

SECTION III
PLANNED EXPENDITURES



Table 2 State Agency Planned Expenditures

Mental Health BG Planned Expenditures

CMHS (07/01/2023 to 06/30/2025)	Mental Health Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds	State Funds	Local Funds	Other	COVID-19	ARP	BSCA
2.b. Mental Health Primary Prevention	200,000	-	-	-	-	-			
3. FEP	1,757,986	-	-	-	-	-	535,865	950,000	55,739
6. State Hospitals	-	20,000,000	8,000,000	140,000,000	-	78,000,000			
7. Other 24 Hour Care	-	8,000,000	-	10,000,000	-	-			
8. Ambulatory/Community Non-24 Hour Care	13,905,745	190,000,000	6,500,000	60,000,000	-	6,000,000	4,299,681	7,622,619	447,238
9. Administration	837,136	-	250,000	7,000,000	-	8,000,000	255,174	452,381	26,542
10. Crisis Services	878,993			50,000,000		400,000	267,933	475,000	27,869
Total	17,579,860	218,000,000	14,750,000	267,000,000	-	92,400,000	5,358,653	9,500,000	557,388

Substance Use BG Planned Expenditures

SAPT (07/01/2023 to 06/30/2025)	SU Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds	State Funds	Local Funds	Other	Covid-19	ARPA
1. Substance Abuse Prevention and Treatment	19,859,828	-	19,731,355	13,909,840	-	-	3,453,265	3,924,164
1.a. Pregnant Women and Women with Dependent Children	-	-	-	-	-	-		
1.b. Recovery Support Services	-							
1.c. All Other	19,859,828	-	-	-	-	-	3,453,265	3,924,164
2. Substance Abuse Primary Prevention	5,655,002	-	-	-	-	-	983,303	1,117,389
3. Tuberculosis Services	-	-	-	-	-	-	-	-
4. Early Intervention Services (HIV)	1,413,751	-	-	-	-	-	245,826	279,347
10. Administration	1,346,429	-	182,138	5,349,446	-	-	234,120	266,045
Total	28,275,010	-	19,913,493	19,259,286	-	-	4,916,513	5,586,946

Table 4

Planning Period 10/1/2023 to 9/30/2024

	FY 2024 SA Block Grant Award	COVID-19 Award	ARP Award
1. Substance Abuse Prevention and Treatment	9,929,914	5,552,523	3,924,164
2. Primary Prevention	2,827,501	1,552,583	1,117,389
3. Tuberculosis Services	-	-	-
4. Early Intervention Services Regarding HIV	706,875	388,146	279,347
5. Administration	673,215	269,663	266,045
Total	14,137,505	7,762,915	5,586,946



