Families as Allies
840 E. River Place, Suite 500
Jackson, MS 39202

September 14, 2021

Dear Ms. Stewart –

On behalf of Families as Allies, I respectfully submit the following public comments regarding the Mississippi Department of Mental Health's Mental Health Block Grant application.

1. There seems to be a lack of clarity of the relationship among the Mental Health Planning Council, the Department of Mental Health (DMH) and the development of the State's block grant application. Our understanding of the statute establishing Mental Health Planning Councils, as well as from the Substance Abuse and Mental Health Services Administration (SAMHSA) Statewide Family Network (SFN) program, our national organizations and Federation of Families chapters in other states, is that Councils are to take the lead in conducting the annual needs assessment of the state mental health system, with administrative and logistical support from the state behavioral health authority, which in Mississippi is the DMH. The Council then makes recommendations for how block grant funds are used based on the needs assessment.

   This application seems to describe how the DMH plans to use the block grant funds and how the public can now comment on these plans that have already been made and in many cases have been being executed for several months. Most of the specific planned activities are not referenced in meeting minutes, and, when they are, they are described as activities the DMH has already initiated. Meeting minutes also reflect that it is primarily DMH staff who run and speak at Council meetings.

   Unless we overlooked it, the federally mandated needs assessment is not described in the application other than a reference to asking the community mental health centers (CMHCs) for input on spending supplemental funds and broad statements about getting feedback from many interagency groups. This is concerning given that primary the purpose of the Council is to bring the perspective of people receiving services, their families and other stakeholders who are not state employees or mental health providers, and it is this perspective that is supposed to be the driving force of the plan.

   We realize that these issues cannot be corrected for this year's report, but the concern could be acknowledged, including that Melody Worsham has brought up concerns in this regard that could be used as an opportunity to refocus the Council. We also recommend that the DMH request technical assistance in this area and this technical assistance be provided to the Council and DMH separately so that each group can learn its respective role in supporting an effective Council.

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2. Another general concern is that the plan focuses on a number of specific services the DMH plans to provide rather than broader infrastructure approaches to create and sustain services and leverage opportunities (for example, using SOC grants to address broad infrastructure needs rather than simply to provide services in a given geographical area for a few years) to help make this happen. One of the greatest challenges to Mississippi's mental health system is that there is no overarching coordination of all of the pieces so therefore the infrastructure of the mental health system is very weak. Continuing to add service project after service project without any overarching coordination across all systems with mechanisms to be accountable to service recipients, their families and the public does not address the infrastructure needs and actually seems to make things more splintered and siloed. Addressing this would include strategic partnerships among agencies that are transparent, legally binding, have public meetings and are fully inclusive of people receiving services and their families.

   This is another issue that cannot be addressed through updating the report, but it can be acknowledged as a significant need that the state is aware needs to be addressed in partnership with the council.

3. This plan focuses on process goals rather than outcomes. We suggest requesting technical assistance to look at this issue.
4. This plan references several interagency groups. The membership of some of these groups are defined in statute (such as the Interagency Coordinating Council for Children and Youth) or by outside regulatory agencies (the 988 planning group). Other groups appear to be created by the DMH and then members chosen by the DMH (the Executive Steering Committee, possibly the Suicide Prevention group). Internally defined and chosen groups decrease the likelihood of broad, objective stakeholder input to guide plans, including the block grant application.

   The DMH strategic plan is referenced in the application. It is unclear who creates the DMH strategic plan. No planning committees or members are listed in the DMH strategic plan. Public comments that we have submitted on the plan have not been responded to and we do not know if and/or where our public comments have been posted.

   We recommend that going forward the DMH rely only on externally defined interagency groups that have objective processes for accountability for activities related to the block grant application. We also think urge the DMH to use this approach in all of its work.

5. Although the membership of the council lists a wide range of diverse stakeholders, it is not clear if all of these stakeholders are consistently attending. We would be happy to help with

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outreach to current and potential stakeholders to help ensure broad outreach. This could be mentioned as a strategy.

6. We are great supporters of nationwide 988 implementation, but the plans described in this application seem to have been hastily thought out and to have gaps – for example, how it will coordinate with 911, if the assumption that it should go primarily though the DMH is appropriate, etc. We recommend that these funds be used to gather more data and bring together more stakeholders (including making the opportunity to be on the 988-planning committee publicly available) and that broader group make plans for next steps.
7. We recommend avoiding overuse of beds in community-based options, including looking at ways to use therapeutic foster care outside of child welfare when children need to come out of the home rather than developing separate community facilities for them. We are not aware of an evidence-base for "Safe Homes", but are happy to learn more if there is one. Because it is normal for adolescents to be heavily influenced by peers, creating communal living arrangements when children are having challenges can inadvertently create environments that strengthen the behaviors that are causing challenges. Using therapeutic foster care with additional wraparound services in creative ways can be one way to provide structure in a more home like setting. Joy Hogge started Hope Haven, and although it was a successful model for many years, she, based on those years of experience, recommends the idea of more broadly using therapeutic foster care and other approaches that don't put youth together as a way to move away from communal residential services and its inherent challenges. We are happy to help explore and research this idea if there is openness to it.
8. One of the challenges we see with school -based mental health services is that they are not coordinated with special education services and sometimes appear to be used as a way for districts to avoid identifying children under the federal Child Find mandate of IDEA. Mental health providers are sometimes not familiar with what districts are legal mandated to do. Our recent survey of children's coordinators revealed that about half did not have this familiarity and would benefit from more support. When school-based services are used to circumvent the identification of children for special education, it violates children's rights and also may mean that districts are not following federal law. We are happy to work with the DMH and Council to look at how school -based services could be developed in a way that avoids this situation. We can also have the capacity to provide training and support to MH providers in understanding IDEA and how it can coordinate with school-based mental health services. We do not think any new school-based services should be developed until this issue is addressed.
9. Evidence for mental health courts is not consistent, especially when studies and factors are closely examined. They can also inadvertently criminalize mental illness, Rather than begin by planning to establish a youth mental health court, we would encourage community approaches that would help keep youth from ever coming to the attention of the court system, including working with MAP teams and the families and youth who are part of them to develop ways to

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keep youth from getting to the point of coming attention to the court system – also using MAP teams, a non-justice related intervention, to help youth who enter the system through youth court, rather than creating a separate path. Not creating a separate path would also be consistent with state law that makes it clear that MAP teams are designated as the single point of entry into the System of Care for children with SED and who need the services of at least two systems.

10. The application references high fidelity wraparound. Over the past few months with the various transitions with Mississippi Youth Programs Around the Clock (MYPAC), it has become clear that there may be challenges to Wraparound being implemented consistently with the values of high-fidelity wraparound. We recommend that the Council be made aware of this issue and, along with the ICCCY, look at broad cross system measure that could be used to ensure high fidelity wraparound and the system level structures and supports necessary to support it. We are happy to continue to support this effort.
11. We note that Question #17 is optional. If the State chooses to respond to this question, the response needs to be consistent with the facts. The State was sued and lost under the Supreme Court case the question references, Olmstead vs. LC. This needs to be stated. An Olmstead plan is broadly inclusive of stakeholders, has measurable goals about people living in the community and spans agencies. As far as we know, Mississippi does not have an Olmstead Plan. That is why we have repeatedly recommended that the state use the Olmstead Risk Assessment and Planning Checklist developed by the National Association of State Mental Health Program Directors to bring all stakeholders together to develop one. The DMH's strategic plan appears to be an internal planning document that might help the DMH in looking at issues related to Olmstead, but we would not agree it serves as an Olmstead plan. The strategic plan was cited as being the State's Olmsted plan after there was disagreement in court about the existence of Mississippi's Olmstead Plan.

    If the DMH chooses to respond to this question, we recommend that it also submit hearing transcripts of the State's defense of DMH's approach to Olmstead and request technical assistance regarding if SAMHSA agrees that how DMH's obligations to comply with Olmstead are being described in court are in keeping with the Olmstead obligation SAMHSA describes in this question.

Sincerely,

Joy Hogge

Joy Hogge, PhD

Executive Director