Mississippi

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand, III - Executive Director

August 26, 2011

Virginia Simmons
Grants Management Office, SAMHSA
1 Choke Cherry Road
Rockville, Maryland 20857

Dear Ms. Simmons:

Enclosed is Mississippi's application for the FY 2012-2013 Community Mental Health Services (CMHS) Block Grant. In accordance with application instructions from the CMHS, we have included all related documents and forms to be addressed in Step I. of the application. The Implementation Report, Uniform Data on the Public Mental Health System, and data on National Outcome Measures will be submitted to CMHS no later than December 1, 2011, as required by application guidelines.

We appreciate your assistance and the help our staff receives from the CMHS Block Grant program staff, including our state's Project Officer, Cherrie Couch, in administering this program throughout the year. If you need additional information, please do not hesitate to contact Mr. Matt Armstrong, Director of the Bureau of Community Services, at (601) 359-1288, at the above address or fax number or by email at matt.armstrong@dmh.state.ms.us.

Sincerely,

Edwin C. LeGrand III
Executive Director

cc: Ms. Cherrie Couch
Mr. Larry Waller
Mr. Matt Armstrong
Ms. Kimela Smith
Ms. Lynda Stewart

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FACE SHEET
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

State Name: Mississippi **Plan Year:** FY 2012-2013 **DUNS #:** 809399926

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

Agency Name:	Mississippi Department of Mental Health
Organizational Unit:	Bureau of Community Services
Mailing Address:	239 North Lamar Street, 1101 Robert E. Lee Building
City:	Jackson
Zip Code:	39201

II. Contact Person for the Grantee of the Block Grant

First Name:	Edwin
Last Name:	LeGrand III
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:	ed.legrand@dmh.state.ms.us

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

From: 7/1/2010

To: 6/30/2011

IV: Date Submitted

Submission Date:

Revision Date:

V. Contact Person Responsible for Application Submission

First Name:	Matt
Last Name:	Armstrong
Telephone:	601-359-1288
Fax:	601-359-6295
Email Address:	matt.armstrong@dmh.state.ms.us

Letter of Designation from Governor

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR

HALEY BARBOUR
GOVERNOR

August 2, 2011

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

I hereby certify that the Mississippi Department of Mental Health is designated as the state agency to administer the Community Mental Health Services (CMHS) Block Grant in Mississippi. I have designated Mr. Edwin C. LeGrand III, Executive Director of the Mississippi Department of Mental Health, to apply for the block grant and to sign all assurances and certifications required by federal law and the application guidelines.

If you have any questions, please contact Mr. LeGrand or Mr. Matt Armstrong, Director of the Bureau of Community Services, at (601) 359-1288 or by e-mail at matt.armstrong@dmh.state.ms.us

Sincerely,

Haley Barbour

POST OFFICE BOX 139 • JACKSON, MISSISSIPPI 39205 • TELEPHONE: (601) 359-3150 • FAX: (601) 359-3741 • www.governorbarbour.com

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

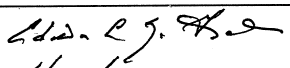
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Edwin C. LeGrand III
Title	Executive Director
Organization	Mississippi Department of Mental Health

Signature 

Date 6/25/11

Footnotes:

I: State Information

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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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 (45 CFR Part 93).

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)

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.

Name	Edwin C. LeGrand III
Title	Executive Director
Organization	Mississippi Department of Mental Health

Signature Edwin C. LeGrand III

Date 8/25/11

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Mississippi agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Edwin C. LeGrand III
Title	Executive Director
Organization	Mississippi Department of Mental Health

Signature

Date 8/25/11

Footnotes:

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II: Planning Steps

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

Overview of the State Mental Health System

The State Public Mental Health Service System

The public mental health system in Mississippi is administered by the Mississippi Department of Mental Health, which was created in 1974 by an act of the Mississippi Legislature, Regular Session.

Organizational Structure of the Mississippi Department of Mental Health

The structure of the DMH is composed of three interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-operated facilities and community services programs.

Board of Mental Health - The Department of Mental Health provides leadership in coordinating mental health services within the broader system through both structural and functional mechanisms. DMH is governed by the State Board of Mental Health, whose nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and citizen representatives from each of Mississippi's five congressional districts (as existed in 1974). Members' seven-year terms are staggered to ensure continuity of quality care and professional oversight of services.

DMH Central Office – The Executive Director directs all administrative functions and implements policies established by the State Board of Mental Health. DMH has a state Central Office for administrative, monitoring, and service areas. The Division of Legal Services and the Director of Public Information report directly to the Executive Director.

DMH has eight bureaus: Administration, Mental Health, Community Mental Health Services, Alcohol and Drug Abuse Services, Intellectual and Developmental Disabilities, Interdisciplinary Programs, Quality Management, Operations and Standards, and Workforce Development and Training.

The Bureau of Administration works in concert with all Bureaus to administer and support development and administration of mental health services in the state. The Bureau of Administration provides three major services, including accounting, auditing and information/data management. The Division of Information Systems (which provides support to the Bureau of Mental Health, the Bureau of Community Services and its service provider network in data management is part of the Bureau. The Bureau of Administration includes the following divisions: Accounting, Audit and Grants Management, and Information Systems.

The Bureau of Community Mental Health Services has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with

the care and treatment of persons with Alzheimer's disease/other dementia. The Bureau of Community Mental Health Services provides a variety of services through the following divisions: Certification, Mental Health Community Services (for Adults), Children and Youth Services, Alzheimer's Disease and Other Dementia, Planning, and Consumer and Family Affairs. The Division of Planning provides administrative support to the Mental Health Planning and Advisory Council and supports Bureau of Community Services staff in developing the State Plan and other planning, training and research activities.

The Bureau of Alcohol and Drug Abuse Services is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems, including state Three-Percent Alcohol Tax funds for DMH. The overall goal of the state's substance abuse service system is to provide a continuum of community-based, accessible services, including prevention, outpatient, detoxification, community-based primary and transitional residential treatment, inpatient and aftercare services. Community-based alcohol/drug abuse services are provided through the regional community mental health centers, state agencies, and other nonprofit programs. The Bureau includes the Division of Prevention Services and the Division of Treatment Services.

The Bureau of Mental Health oversees the six state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services as well as the Central Mississippi Residential Center and the Specialized Treatment Facility**,** a specialized treatment facility for youth with emotional disturbances whose behavior requires specialized treatment.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for individuals in the state with intellectual and developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive regional centers for individuals with intellectual and developmental disabilities, one juvenile rehabilitation center for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services. The Bureau of IDD also operates the ID/DD Home and Community-Based (HCBS) Waiver.

The Bureau of Interdisciplinary Programs works with all other DMH programmatic bureaus, DMH facilities, and DMH-certified programs. The Bureau of Interdisciplinary Programs facilitates and coordinates the collection of information to develop reports, formulate policies, and develop rules and regulations as necessary for the Board of Mental Health and Executive Director; develops strategies for project management and organization; and, completes special projects for the Board of Mental Health and DMH. The Bureau Director of Interdisciplinary Programs serves as the liaison to the Board of Mental Health, and provides administrative leadership in the planning, directing, and coordinating of the *Board of Mental Health and DMH Strategic Plan*.

The Bureau of Quality Management, Operations and Standards is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH Standards, development of the peer review system as a part of DMH's overall quality management, provision of support to programmatic divisions/bureaus with DMH to assist with information management and reporting, oversight of agency and provider emergency

management/disaster response systems to ensure continuity of operations within the public mental health system, oversight of constituency services, and the future development of agency and provider performance measures. The Bureau of Quality Management, Operations and Standards is comprised of the following divisions/offices: Division of Certification, Office of Consumer Supports, Division of Disaster Preparedness and Response, and Suicide Prevention.

The Bureau of Workforce Development and Training advises the Executive Director and State Board of Mental Health on the human resource and training needs of the agency, assists in educating the Legislature as to budget needs, oversees the leadership development program, and serves as liaison for DMH facilities to the State Personnel Board. This Bureau includes the Division of Professional Development and the Division of Professional Licensure and Certification.

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 MS Department of Mental Health 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, such as the MS State Mental Health Planning and Advisory Council; the Regional Commissions Group, members of which include the governing boards or commissions of community mental health centers; and, various task forces and committees that engage in ongoing efforts to improve the service system.

State Mental Health Agency's Authority in Relation to Other State Agencies

The MS Department of Mental Health is under separate governance by the State Board of Mental Health, but oversees mental health, intellectual/developmental disabilities, and substance abuse 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 Part IV. N. Support of State Partners.

Description of Regional Resources

The mental health service delivery system is comprised of three major components: regional community mental health centers, state-operated facilities and community services programs, and other non-profit/profit service agencies/organizations.

Regional community mental health/mental retardation centers operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 15 regional centers make available a range of community-based mental health services, as well as substance abuse and intellectual/developmental disabilities services to all 82 counties in Mississippi. (See maps and list of community mental health centers on the next pages.) The governing authorities are considered regional and not state-level entities. The Mississippi Department of Mental Health is responsible for certifying, monitoring, and assisting the regional community mental health centers. These regional community mental health centers are the primary service providers with whom the Department of Mental Health contracts to provide community-based services. In addition to state and federal funds, these centers receive county tax funds and generate funds through sliding fees for services, third party payments, including Medicaid, grants from other agencies such as the United Way, service contracts, and donations.

Generally, community mental health centers have the first option to contract to provide mental health services within their regions when funds are available. The same regional commission legislation that provides for the structure of the community-based regional (multi-county) commissions also authorized participating counties to levy up to two mills tax for programs designed by the regional commission. As a result of this, county tax money preceded state money in the community mental health programs throughout the state. Rather than assess a specific tax, however, counties now make contributions for mental health services from their general tax assessment. The Department of Mental Health is prohibited from funding services at any regional community mental health center that does not receive a specified minimum level of support from each county in the region. That minimum level is the greater of (1) the proceeds of a ¾ mill tax in 1982 or (2) the actual contribution made in 1984.

The total received from all counties is approximately 3% of total community mental health center receipts. During the last few years, the community mental health centers have made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTERS	
Region 1: Coahoma, Quitman, Tallahatchie, Tunica	Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267
Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655

	(662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	Region III Mental Health Center Robert Smith, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662) 844-1717
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Timber Hills Mental Health Services Charlie D. Spearman, Sr., Executive Director 303 N. Madison St. P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 5: Bolivar, Issaquena, Sharkey, Washington	Delta Community Mental Health Services Richard Duggin, Executive Director 1654 East Union Street P. O. Box 5365 Greenville, MS 38704-5365 (662) 335-5274
Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower	Life Help Madolyn Smith, Executive Director Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211
Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston	Community Counseling Services Jackie Edwards, Executive Director 302 North Jackson Street P. O. Box 1188 Starkville, MS 39760-1188 (662) 323-9261

Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)
Region 9: Hinds	Hinds Behavioral Health Margaret L. Harris, Director P.O. Box 777, 3450 Highway 80 West Jackson, MS 39284 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 4378 Meridian, MS 39304 (601) 483-4821

Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	Southwest MS Mental Health Complex Steve Ellis, Ph.D., Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jeff Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 1030 Hattiesburg, MS 39403 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Jeffrey L. Bennett, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Mental Health Services Steve Roark, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

State-operated Facilities: DMH administers and operates six state psychiatric facilities, five regional centers for people with intellectual and developmental disabilities, and a juvenile rehabilitation facility. These facilities serve specified populations in designated counties/service areas of the State.

The psychiatric facilities provide inpatient services for adults with serious mental illness and children with serious emotional disturbances. These facilities include Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. Nursing facility services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital.

The Regional Centers provide on-campus, and community-based residential services for persons with intellectual and developmental disabilities. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

The Mississippi Adolescent Center (MAC) in Brookhaven is a residential facility dedicated to providing adolescents with intellectual and developmental disabilities an individualized array of rehabilitation service options. MAC serves youth who have a diagnosis of intellectual and

developmental disabilities and whose behavior makes it necessary for them to reside in a structured therapeutic environment. The Specialized Treatment Facility in Gulfport is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment.

State-operated Community Service Programs: All of the psychiatric facilities and regional centers provide community services in all or part of their designated service areas. Community services include: residential, employment, in-home, and other supports to enable people to live in their community. Central Residential Mississippi Residential Center operates the Crisis Stabilization Unit in Newton, Mississippi, as well as group homes, supervised apartments, day programs and programs for individuals with Alzheimer's disease and other dementia.

Other nonprofit service agencies/organizations make up a smaller part of the service system. They are certified by 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/drug abuse services, community services for persons with intellectual/ developmental disabilities, and community services for children with mental illness or emotional problems.

State Certification and Program Monitoring The Mississippi Department of Mental Health ensures implementation of operational standards for community programs certified through the authority of the Department of Mental Health. Standards have been developed by the Department of Mental Health, approved by the State Board of Mental Health, and registered with the Mississippi Secretary of State's Office. The standards establish requirements for programs in organization, management, and in specific service areas to attempt to assure the delivery of quality services. The Department ensures implementation of services that meet established operational standards through its ongoing certification and site review process. Reviews are conducted by representatives from the Division of Community Services, the Division of Children and Youth Services, the Bureau of Alcohol and Drug Abuse Services, and the Division of Certification. All community programs receiving funding through the Department must also submit monthly reports with their requests for reimbursement, which include service delivery and financial information. Bureau of Administration staff perform fiscal audits of programs receiving funding through the Department of Mental Health.

State Role in Funding Community-Based Services The authority for funding programs to provide services to persons in Mississippi with mental illness, mental retardation, and/or alcohol/drug abuse problems by the Department of Mental Health 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 MS Department of Mental Health is a general state tax fund agency. Section 41-4-7(1) of the MS Code states that the Department of Mental Health is:

> "to serve as the single state agency in receiving and administering any and all funds available from any source for the purpose of training, research and education in regard to all forms of mental illness, mental retardation, alcoholism, drug misuse and developmental disabilities, unless such funds are specifically designated to a particular agency or institution by the federal government, the Mississippi Legislature, or any other grantor."

The FY 2012-2013 State Plan includes objectives related to state funds that were appropriated for specific purposes by the State Legislature in 2011. Objectives and targets for FY 2013 may be modified based on funding appropriated in 2012. Agencies or organizations submit to the Department 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, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health. Applications for funding are reviewed by staff in the DMH, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP, (2) the applicant's provision of services compatible with established priorities, and (3) availability of resources.

Federal and State Resources

The FY 2012-2013 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2011 Session for FY 2012. The Department of Mental Health (DMH) administers and grants to local providers funding from the federal Community Mental Health Services (CMHS) block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants. The DMH requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. For several years of budget restrictions, the community mental health centers have also made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers.
The legislation that provides for the establishment, structure and operation of the regional commissions for mental health/mental retardation also authorizes participating counties to levy up to two mills tax for programs designed by the regional commission. The DMH also performs fiscal audits of programs receiving funding through its Bureau of Administration.

Strengths and Needs of the Service System

Strengths: Children with serious emotional disturbance (SED) and their families

- The Mississippi Transitional Outreach Program (MTOP), a Children's Mental Health Initiative targeting transitional-age youth, 16-21 years, The Mississippi Transitional Outreach Program (MTOP) began implementation October 1, 2010 in two Community Mental Health Center regions. On October 1, 2011, two more regions will be added for a total of four MTOPs by the end of the six year grant period, 2015.

- A commitment to an interagency, collaborative approach to system development and improvement, both at the state and local levels, has remained inherent in efforts to build and transform the system over time. New legislation expanding the ICCCY and ISCC was passed in March 2010 with provisions for increased local participation from agencies on local MAP Teams. The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances with complex needs that usually require the intervention of multiple state agencies. The DMH provides flexible funding to this state-level team and to local interagency Making

A Plan (MAP) teams that are designed to implement a wrap-around approach to meeting 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 Human Services (DHS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services, as well as adolescent offender programs across the state.

- 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 of staff from other child and family support service agencies. Collaborative training initiatives include Wraparound 101 and System of Care by staff at the Innovations Institute at the University of Maryland; MAP team development and expansion; Youth Suicide Prevention; juvenile mental health issues; and cross - system improvement trends and best practices.

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. Grant funding from the Department of Public Safety, Office of Justice Programs was received January 2010, to improve access to appropriate mental health services and supports from the local community mental health centers.

- Efforts have been initiated to provide training in evidence-based practices to clinicians in the CMHCs and other nonprofit programs to improve responses to youth and families in crisis, including those with a history of trauma.

- The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges.

- The Fetal Alcohol Spectrum Disorder (FASD) Project has continued to focus on the screening and assessment of children, 0-7 years of age through the 15 Community Mental Health Centers. The Advisory Council of FASD is focusing on the treatment and services received by those children with a FASD to determine best practices for this target population.

Needs: Children with serious emotional disturbance (SED) and their families

- The need to 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.

- The need to address children with co-occurring disorders of serious emotional disturbance and intellectual and developmental disabilities in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross

system collaboration and education.

- Continuing work to improve the information management system is needed 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 is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Availability of additional workforce, particularly psychiatric/medical staff at the local community level, who specialize in children's services, is an ongoing challenge in providing and improving services.

- The need to increase respite services and family education/support services for those families and caregivers who undergo the constant strain of caring for youth with SED are needed to keep children/youth from being inappropriately placed in residential care.

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. DMH has continued efforts to improve the clubhouse programs by providing technical assistance on the International Center for Clubhouse Development (ICCD) programs model; ICCD-certified programs have been developed that can serve as more cost-effective in-state training sites. The DMH Division of Community Services plans to expand the ICCD certified clubhouses to each region in the state
- DMH has developed a range of community-based service options that can be accessed to address the individualized and changing needs of individuals with serious mental illness, such as senior psychosocial rehabilitation services and day support. DMH continues to offer three training sites in Regions 6, 12, and 15.

- DMH has maintained a long-term commitment to improve its system of crisis response and continuity of care for individuals who have been or who are at risk for hospitalization. Addressing this issue requires multiple strategies, given interaction with local courts around civil commitment, the fact that individuals and families in crisis frequently lack financial resources, as well as the limited resources of many local communities to address emergency care needs. The Department of Mental Health has developed two transitional group homes in the Region 3 CMHC service area for individuals with mental illness and intellectual disabilities who have been frequent users of the justice system and the state psychiatric hospital system.

- Regionalization of acute care/crisis services has been advanced through the opening of two, 50 bed acute psychiatric hospitals for adults to serve the northern and southern areas of the state. DMH funds seven (7) sixteen (16) bed Crisis Stabilization Units and partially funds one (1) twenty-four (24) bed Crisis Stabilization Units throughout the state. All but one (1) are operated by the Community Mental Health Center Regions. All Crisis Stabilization Units take voluntary as well as involuntary admissions.

- The DMH Division of Community Services and the DMH Bureau of Alcohol and Drug Abuse Services have a history of consensus and collaboration in continuing efforts to better address the needs of individuals with co-occurring mental illness and substance abuse disorders. DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. In 2010, DMH received federal Transformation Transfer Initiative (TTI) funding to support training on conducting assessments, developing treatment plans, and providing integrated services and treatment for co-occurring disorders in community mental health regions and state hospitals.

- The perspectives of individuals receiving services and families have long been important in planning, implementing and evaluating the adult service system, contributed through their involvement in numerous task forces, the peer review process and more recently, through provider education and the person-directed planning process. The Division of Consumer and Family Affairs has implemented initiatives to provide more specific guidance regarding the purpose and structure of local advisory councils, has developed a draft of a manual to provide technical assistance to the local advisory councils and plans to develop a strategy for dissemination of educational information to the local councils.

- The DMH maintains an accessible, structured system for reporting and resolving of grievances and problems in programs certified by the agency (both formally and informally), as well as for providing information on statewide service availability, through its Office of (OCS) Consumer Supports. OCS maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. The OCS has also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran.

- The DMH Division of Community Services has continued to work closely with other agencies, such as the Division of Medicaid, to plan and implement system changes. DMH worked with the Division of Medicaid to explore the possibility of a proposed State Plan Amendment and/or a waiver for submission to the Center for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community based services to further support resilience/recovery.

- SAMHSA Transformation Transfer Initiative (TTI) funding enabled the DMH to receive much-needed specialized technical assistance from consulting entities with expertise in planning housing and housing-related support services to advise and support statewide strategic planning for housing for individuals served by the public mental health system. Technical assistance provided through the TTI project gave DMH staff a vital educational foundation and focused planning efforts on key elements that must be addressed in the development of permanent supportive housing and housing related support services. The project also resulted in the establishment of working relationships with key housing

partners. Additionally, as a result of the ongoing communication, interactions and analyses of information in the TTI project, housing consultants identified key policy and operational issues, and made recommendations to DMH leadership for design and implementation of strategies to expand access and availability of housing and related supports, as well as to address infrastructure and related budget development to support next steps in the housing initiative.

- Efforts to address outreach and specialized approaches that are more responsive to the needs of individuals with serious mental illness who are homeless have involved ongoing collaboration and creativity among the DMH and other agencies and organizations that serve homeless persons. DMH was recently approved to receive the SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance to provide specific training to PATH and housing providers and other stakeholders. The DMH has collaborated with The Social Security Administration, Disability Determination Services, Veterans Affairs and other organizations to plan SOAR Training for various regions across the state. In March 2011, DMH conducted its first SOAR Training for providers.

- DMH has continued to emphasize the importance of the role of case management in the adult service system and provides case management orientation for local service providers on an ongoing basis throughout the year. A Case Management Task Force has maintained its focus on improving case management services, including linkage with other types of support services. Also as mentioned, the DMH has completed work on development of a Case Management Certification Program for individuals working in the public mental health system. The process to become a Credentialed Certified Case Management Professional has been revised to adjust to the accessibility and innovation of distant learning technology. The requirement for initial orientation to service delivery can now be completed online.

- DMH has continued efforts to develop the Peer Specialist program to enhance employment opportunities to individuals with serious mental illness. Individuals with mental illness have been employed by the DMH to support the peer review process and consumer educational events, as well as to facilitate planning and development of a peer specialist program and employment opportunities. In FY 2008, consumers employed by DMH in the new Division of Consumer and Family Affairs completed Certified Peer Specialist Training in Kansas. Staff from the Division, as well as local provider and NAMI-MS representatives visited peer support programs in Georgia and received technical assistance on program development from certified peer specialists, Medicaid representatives, and Georgia Department of Mental Health staff. Activities to develop peer specialist services continued. The first class of interested consumers received training in the provision of peer specialist services, based on the Georgia model in May 2009, and a workshop for providers interested in peer specialist services was provided as part of the 2009 Mental Health Community Conference. The Bureau of Community Services will also continue efforts to obtain funding support to provide peer specialist services, including submission of an application for a SAMHSA Mental Health Transformation grant.

- As noted under the strengths for children's services, continuity of administration and experience at both the state and local levels among service providers and advocates have

facilitated adherence to ideal system model principles and progress in addressing gaps in the system.

- Additionally, as in the implementation of the children's services systems, recognition of and commitment of resources to providing training, including technical assistance and credentialing programs, characterize strategies for quality improvement for all adult services.

- To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) and the Think Again Network launched a mental health awareness campaign entitled, Think Again. The campaign, which was launched in 2009, was designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign, which reached an estimated one million individuals in FY 2010. In DMH and the Think Again Network will continue to show young adults how to support their friends who are living with mental health problems. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. Combined, these campaigns teach young adults about mental health and suicide prevention. Materials and presentations for both campaigns were combined in order to present a more concise and consistent message.

- The DMH Division of Community Services continues worked to develop and pilot three AMAP (Adult Make A Plan) Teams. Division of Community Services staff collaborates with Division of Children and Youth Services staff to receive training on wrap-around services; the Division is working with the person-directed planning training sites in Regions 12 and 15 to include this approach in AMAP training. In 2011, the Division of Community Services added an additional AMAP Team in Region 4. DMH will continue to support and expand AMAP efforts across the state. DMH anticipate funding cuts in both of these areas. DMH, however, continues to explore other funding avenues to maintain and expand these services. In 2012, it is anticipated that the Division of Community Services will add five additional AMAP teams across the state.

Needs: Services for Adults with serious mental illness (SMI)

- The need for additional transportation options, with more flexible scheduling, continues to be a need across the state for individuals with disabilities, including individuals with serious mental illness. Maximizing transportation resources available across agencies is key to providing individuals with services and supports that enable them to be independent, such as employment and housing. Additional resources are needed to begin implementation of the plan for transportation that is being developed by the Mississippi Coordinated Transportation Coalition. The DMH continues with the Coalition to explore funding opportunities to consistently coordinate transportation planning in the state.

DMH will utilize small funding streams to assist in piloting the provision of transportation to individuals with disabilities.

- The need for increased supported and independent employment options for adults with serious mental illness is ongoing.

- Continued work to increase access to 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).

- Continuation of law enforcement training to reach additional experienced officers in communities, as well as strategies to address needs of other emergency services personnel is needed. Additional efforts are being made to address this issue through increased education and networking with law enforcement associations. DMH will utilize small funding streams to assist in the cost of these rides to individuals with disabilities.

- The Division of Community Services is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. DMH makes grants available to CMHC regions to provide training to law enforcement and has also explored several funding opportunities to facilitate the establishment of Crisis Intervention Team (CIT) training of officers in the state.

- Continued focus on improving transition of individuals from state hospitals, back to their home communities is needed, in particular, development of strategies to better target and expand intensive supports, preferably through a team approach. Currently plans are to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.

- As in the children's services systems, increasing the skill-level of community mental health service providers to affect system changes reflected throughout the plan remains a need.

- Work to improve the information management system is needed 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 is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

Step 2: Identify the Unmet Service Needs and Critical Gaps

Mississippi utilized final methodology for estimating prevalence of serious emotional disturbance among children and adolescents, as published by the (national) Center for Mental

Health Services (CMHS) in the July 17, 1998, issue of the Federal Register. The estimated number of children, ages 9 through 17 years in Mississippi in 2009 is 375,918. Mississippi remains in the group of states with the highest poverty rate (21.5% age 5-17 in poverty, based on 2008 Federal poverty rates), 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 2009 are as follows:

- Within the broad group (9-13%), Mississippi's estimated prevalence range for children and adolescents, ages 9-17 years, is 11-13% or from 41,351 – 48,869.
- Within the more severe group (5-9%), Mississippi's estimated prevalence range for children and adolescents, ages 9-17 years, is 7-9% or from 26,314 – 33,833.

For transitional age youth, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (134,710**), yielding an estimated prevalence of 12,393 in this transition age group.
According to the 2003-2006 National Survey on Drug Use and Health (NSDUH) , in Mississippi, 9,000 males and 8,000 females abused or were dependent on alcohol or drugs in the past year. Approximately 9,000 Mississippi adolescents (12 to 17 years) needed but did not receive treatment for alcohol problems or for past-year drug problems (SAMHSA, Office of Applied Studies, September 2009).

In FY 2009, 30,199 children with serious emotional disturbance were served through the public community mental health centers and other nonprofit providers of community services (Mississippi State Plan for Community Mental Health Services, FY 2011).
Adults

Mississippi utilized the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the (national) Center for Mental Health Services in the June 24, 1999, issue of the Federal Register. The estimated number of adults in Mississippi, ages 18 years and above is 2,168,103, based on U.S. Census 2009 population estimates. According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 117,078 in 2009.

In FY 2009, 53,910 adults with serious mental illness were served through the public community mental health system in Mississippi. Services were provided in all 15 mental health regions and by the community services division of one psychiatric hospital to 9,295 individuals with co-occurring disorders (Mississippi State Plan for Community Mental Health Services, FY 2011.) According to the 2003-2006 National Survey on Drug Use and Health (NSDUH), the rates of individuals ages 18-25 who need drug treatment were below the national average, and the rates of individuals who need alcohol treatment are among the lowest in the country (SAMHSA, Office of Applied Studies, December 2008).

Data and other information used to identify unmet needs/critical gaps in the service system are obtained from a variety of sources and processes.

DMH administrative staff evaluate the status of the system against national trends and reports, such as the Report of the President's New Freedom Commission on Mental Health (July 2003), SAMHSA's Strategic Initiatives and feedback from State Plan review meetings and on-site monitoring visits. Similarly, staff review and consider feedback received through annual external review of the State Plan by the Planning and Advisory Council and the State Board of Mental Health.

The DMH tracks progress on specific, annual objectives that are steps toward broader system goals to increase services or enhance existing services within service systems. Progress on these objectives is tracked by analyzing aggregate reports of administrative data received from local community service providers and data maintained by Central Office staff within an internal report system (reports of on-site visits to service providers, Central office staff activity logs/reports, task force minutes and reports, etc.). Results of site visits, as well as of peer review visits, are documented through a structured reporting and feedback system that includes required plans of correction that address deficiencies in meeting operational standards set by DMH. DMH staff make follow-up visits to monitor implementation of approved plans of correction. Such ongoing, regular visits to local programs are key to identifying unmet needs. Administrative data from the state psychiatric hospitals are also routinely submitted/reviewed by DMH management staff. Efforts to transition to a central data repository system, as well as to integrate consumer and family satisfaction and additional data focusing on system-level and consumer and family-centered outcomes to better evaluate progress on objectives continue. DMH's federal data infrastructure grant is being used to support much of this work.

The DMH also continues to gain direct feedback on unmet needs from family members, consumers, local service providers, and representatives from other agencies through numerous task forces that focus on critical issues (such as co-occurring disorders, homelessness, children's services and case management). The DMH has also benefited greatly from the continuity of its relationship with the MS State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH is implementing statewide consumer and family (for children) satisfaction surveys as another means of collecting feedback from individuals served by the system.

In addition to considering estimates of prevalence for the targeted groups, results of a statewide consumer survey, public forums and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness; for example, major needs for transportation and housing were identified. For example, as part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided DMH with state level population data and various indicators of poverty and disability (such as SSI data) for non-elderly disabled adults, since the focus of the planning initiative was on permanent supportive housing for adults with serious mental illness.

The DMH Division of Children and Youth Services gains additional 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, and through the work of the State-level Interagency Case Review Team, the Interagency

Coordinating Council for Children and Youth (ICCCY), and two Comprehensive System of Care Projects, commUNITY cares and the Mississippi Transitional Outreach Program described in more detail in the State Plan.

The DMH management staff also receives regular reports from the Office of Consumer Supports (OCS), which as mentioned, 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.

Step 3: Prioritize State Planning Activities

Table 2 Plan Year FY 2012-2013:

	State Priorities
1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
2	Interagency Collaboration for Children and Youth with SED
3	Expansion of System of Care for Children and Youth with SED
4	Integrated Services for Children and Youth with SED
5	Recovery Supports (Combined – SMHA/SSA)
6	Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined – SMHA/SSA)
7	Integration of Behavioral Health and Primary Care Services (Combined – SMHA/SSA)
8	Comprehensive Community-Based Mental Health Systems for Adults with SMI
9	Targeted Services to Rural and Homeless Adults with SMI
10	Management Systems

The primary target populations addressed in the FY 2012-2013 State Plan are children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). Additional target populations and/or services within and including the primary priority populations are noted in Table 2.

Priority 1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

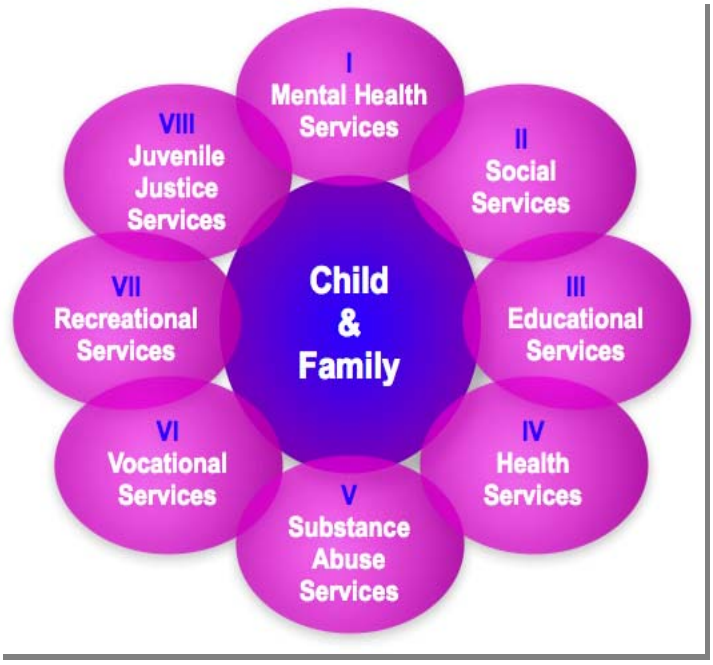
Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. The need for mental health as well as other special needs services and support services 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 15 regional mental health/mental retardation 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, family education and respite and prevention/early intervention services. Public inpatient services are provided directly by the MS Department of Mental Health (described further later under this criterion). The Department of Mental Health remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Acute Inpatient Services, Medication Maintenance, Respite Services, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early Periodic Screening, Diagnosis and 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. Psychological and developmental evaluations, services for children under age three (3) and services in excess of service standard must be prior authorized by the Division. The service standards are: Individual therapy, 36 visits per year, family therapy, 24 visits per year, and group therapy, 45 visits per year.

Mississippi's System of Care for Children and Youth

Mississippi recognizes that a System of Care (SOC) is a coordinated network of community-based services and supports based on the values of cultural/linguistic competency, family-driven and youth-guided care and community – based resources. A System of Care is not a program, but a philosophy of how care should be delivered. A System of Care considers all life domains rather than addressing just the mental health treatment needs in isolation. There are eight overlapping dimensions:



Mississippi was one of the first states to create a foundation for systems of care. Beginning with state legislation in 1993, Mississippi developed local multidisciplinary assessment and planning teams for youth with multiple agencies and established a Children's Advisory Council that focused on using pooled funding to better serve youth. Subsequent legislation established and strengthened a statewide system of care structure, with local Multidisciplinary Assessment and Planning (MAP) Teams around the state and the creation of the Interagency Coordinating Council for Children and Youth (ICCCY) and a mid-level management team, the Interagency System of Care Council (ISCC). Membership on the ICCCY includes Executive Directors of the following state child-serving agencies: MS Department of Education, MS Department of Mental Health, State Department of Health, Department of Human Services, Division of Medicaid (Office of the Governor), State Department of Rehabilitation Services and Mississippi Families As Allies for Children's Mental Health, Inc. The ICCCY is charged with leading the development of the statewide system of care through the established Interagency System of Care Council (ISCC), consisting of a member of each state agency, a family member representing a family education and support organization, two special organization representatives, and a family member appointed by MSFAA. The ISCC services as the mid-level management teams with the responsibility of collecting and analyzing data and funding strategies, coordinating local MAP Teams, and applying for grants from public and private sources.

The most recent System of Care legislation, HB 1529 passed in 2010 Legislative Session, revised and expanded the ICCCY and ISCC membership. The new membership includes representatives from the Attorney General's office, MAP Team Coordinator, Child and Adolescent Psychiatry, the ARC of MS, faculty member from a local University, Early Childhood Development/Education, youth and an additional parent/family member. These three bodies (ICCCY, ISCC, MAP Teams) provide for the development and implementation of a coordinated interagency system of necessary services and care for children and youth up to age 21 with serious emotional/behavioral disturbances who require services from multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

Priority 2: Interagency Collaboration for Children and Youth with SED

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

The executive level Interagency Coordinating Council for Children and Youth (ICCCY) and mid-level Interagency System of Care Council (ISCC), work together to advise the Interagency Coordinating Council in order to establish a statewide system of local Making a Plan (MAP) teams. (For membership see Priority 1).

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 Human Services; the Division of Medicaid; the Attorney General's Office; the Department of Health; the Department of Education, the Department of Rehabilitation Services and MS Families As Allies for Children's Mental Health. 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 more than one out-of-home psychiatric treatment, 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 will have priority.

Making A Plan (MAP) Teams employ a systems-based wraparound approach in developing a family-centered multi-disciplinary plan, are designed to address individual needs and build on the strengths of youth and their families. 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 human services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice) health department and rehabilitation services. Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. The wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 15 community mental health regions across the state. Fifty-two counties either have a MAP Team or access to one, and all 40 MAP Teams continued to operate statewide and had accessibility to flexible funds.

Department of Mental Health staff participates in a variety of state-level interagency collaboration activities and provide support for interagency collaboration at the local level in the 15 CMHC regions. These efforts involve staff of other key child service agencies or nonprofit organizations at the state and local levels and representatives of parent/family organizations for children with serious emotional disturbance. Notification of education/training activities offered by the DMH Division of Children and Youth Services will be distributed to programs serving runaway/homeless youth made known to the DMH through other child service agencies (primarily the Department of Human Services).

Priority 3: Expansion of System of Care for Children and Youth with SED

Children and Youth Services staff continue to participate in interagency meetings and conferences that provide opportunities for increasing awareness across the service system of available children's mental health services. They also continue to disseminate the CYS resource directory through the agency website as well as provide educational materials to individuals at conferences and meetings, the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances.

Youth Suicide Prevention

The MS Youth Suicide Prevention Council meets at least quarterly and provides leadership for statewide planning and implementation of prevention and early intervention strategies, including implementation of a Comprehensive State Plan for Youth Suicide Prevention. Representatives on the state level council are from the Department of Education, the Department of Health, the Jason Foundation, Jackson State University, Mississippi College, the Office of Attorney General, and Catholic Charities, and also include a survivor of a family member who completed suicide, a child psychologist in private practice, Hurricane Katrina-Related Youth Suicide Grant Local and State Project Coordinators, a Community Mental Health Center Children's Services Coordinator and staff from the Mississippi Department of Mental Health's, Division of Children and Youth Services and Division of Disaster Preparedness and Response.

Provision of Evidence-Based Practices

Mississippi Trauma Recovery for Youth (TRY) Project

The Director of the DMH Division of Children and Youth Services served in an advisory role to the Mississippi Trauma Recovery for Youth (TRY) project, funded through SAMHSA. Catholic Charities, Inc has led this four-year project in the Jackson, tri-county area and the Gulf Coast to raise the awareness about child trauma and to improve access to services for children and youth who have been traumatized. Through partnership with existing community agencies and programs, the project has developed the TRY Network, which is focused on increasing understanding about child trauma, endorsing the use of best practices in serving traumatized children and youth, and promoting collaboration between systems. The TRY Project is also supporting the validation of a strengths-based assessment tool for use with traumatized children and youth**.** TRY of Catholic Charities in Jackson, MS, is a member of the National Child Traumatic Stress Network (NCTSN). In FY 2010, the Mississippi Trauma Recovery for Youth (TRY) Project began a Learning Collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), training participants from CMHC regions, the Specialized Treatment Facility, and the MS Band of Choctaw Indians Behavioral Health.

Wraparound Initiatives in Mississippi

The Division of Children and Youth Services partnered with the Division of Medicaid, MYPAC Program to begin state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. Both agencies are using the University of Maryland's Innovation's Institute training model which includes a three-day Wraparound 101 course, one-day Advanced Wraparound and a 12-18 month process for Coach/Supervision Certification. The Division of Medicaid plans to include Wraparound facilitation in their submission to amend the State Medicaid Plan in FY 2012.

Priority 4: Integrated Services for Children and Youth with SED

Adolescent Offender Programs

The Adolescent Offender Programs, which receive state funding through the Department of Human Services, Division of Youth Services, are designed to be a diversionary program from the state-operated training school. These programs target the areas of the state that have the highest commitment rates to the state training schools. DMH technical assistance continued to be available to CMHCs/other nonprofit programs for day treatment programs serving adolescent offenders, upon request/as needed.

Initiatives to Assure Transition to Adult Mental Health Services

The Division of Children and Youth Services, the Division of Adult Community Services and the Division of Alcohol and Drug Abuse have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. The Transitional Services Task Force was formed to better identify and plan to assess needs of youth, age 16 to 25 years. This Task Force has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Task Force includes representatives from a local mental health center that provides a transitional living program, as well as representatives from the MS Department of Rehabilitation Services, the Office of the Attorney General and the DMH Divisions of Children and Youth Services and Alcohol and Drug Abuse. The Task Force has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. The group has been able to identify ways to address the needs of the transition-age youth in an intensive case management model that utilizes the wraparound approach. Potential goals discussed included development of a resource/service directory to assist parents and professionals involved with this age group and strategies for increasing collaboration specifically targeting the transition age group. The work of this Task Force and its members assisted in the development of a successful grant application for a Children's Mental Health Initiative targeting transition – aged youth. The six-year System of Care grant provides funds for the implementation of four additional Transitional Outreach Programs (TOP) across the state.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services of a provider of a transitional living services program that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. DMH provides funding to four (4) of the six (6) DMH certified transitional therapeutic group homes (Rowland, Harden House, and two programs operated by Hope Village).

Priority 5: Recovery Supports (Combined – SMHA/SSA)

The DMH Strategic Plan sets forth DMH's vision of having individuals who receive services have a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. Initiatives in the State Plan are designed to facilitate a system that is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. 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. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 2 of the DMH Strategic Plan highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long term community supports and other specialized services. Goal 2 of the Strategic Plan also provides a foundation on which DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

Youth Education/Support Initiatives

The Mississippi Families as Allies for Children's Mental Health, Inc. (MS FAA) conducts two Youth Leadership Teams, one located in Jackson called the "Youth Making a Difference" team, which has 20 members and meets monthly during the school year. Meeting topics include conflict resolution, communication skills, alcohol and drug abuse prevention and other skills building activities. MS FAA also coordinates another Youth Leadership Team in the Hattiesburg area of the state, the site of Mississippi's second System of Care (SOC) initiative, commUNITY cares. The SOC group also formed a Youth Advisory Council (YAC) to give input to the commUNITY cares project. Members of both groups have attended national SOC grant meetings, the Georgetown Training Institutes and FFCMH annual conferences; they have also made presentations at major state conferences and university social work classes. Both Youth Teams are supported by mental health block grant funds and SOC grant funds are chapters affiliated with the National Youth MOVE, a new CMHS initiative.

MS Families as Allies for Children's Mental Health, Inc. (MS FAA) conducts the Youth Summer Day Camp attended by 15-20 youth with emotional/behavioral challenges who generally experience problems participating successfully in other community day programs. The Youth Summer Camp also welcomes transition-age teens, who may be excluded from other types of camps. MS FAA will continue to provide this summer program, and a similar therapeutic recreation program at the community cares SOC site, with the intent of communicating that the wraparound principle of "no reject, no eject" can be used as a model to broaden summer program opportunities for youth with special needs. This model gives the teens involved a sense of hope and competency. Based on its Youth Camp experiences thus far, MS FAA believes that these less stressful experiences have a beneficial effect on youths' abilities to cope with their daily challenges at school and in the community and to develop job readiness and independent living skills. Division of Children/Youth staff will continue to support and participate in special projects and activities of MS FAA.

Priority 6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined – SMHA/SSA)

Support for Services for Youth with Co-occurring Disorders

The Division of Children and Youth Services and the Bureau of Alcohol and Drug Abuse collaborate to include sessions at the annual MS School for Addiction Professionals pertinent to co-occurring disorders for youth. The Division of Children and Youth staff continue to monitor

and provide technical assistance to community-based residential programs funded by DMH for adolescents with substance abuse problems which also address problems of youth with co-occurring disorders. Staff in both the DMH Bureau of Alcohol and Drug Abuse and the Division of Children and Youth Services has provided training, information and support to women who may be pregnant or may have children with them while receiving treatment in one of the adult substance abuse residential treatment facilities. A registered nurse at a primary residential Alcohol and Drug treatment facility has been trained and educated by DMH staff to discuss the dangers of drinking while pregnant with the women who are receiving services.

The Co-occurring Disorders Coordinating Committee functions to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse. The group also sponsors an annual conference addressing specific training issues in this area for both adults and children and developed program guidelines for grants to local providers to provide specialized services for individuals with dual diagnoses.

Representatives of the Division of Children/Youth Services serve on the DMH's Co-occurring Disorders Coordinating Committee, along with representatives from the Bureau of Alcohol/Drug Abuse, the Division of Community Services for Adults. Plans are to expand the membership to include additional individuals receiving services and family members. A Division of Children and Youth Services staff member continued to participate on the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-occurring Disorders Coordinating Committee and the Underage Drinking Task Force. Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams.

The Division of Children and Youth Services employs a full-time Fetal Alcohol Spectrum Disorder (FASD) State Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS-AC-FASD) and co-sponsors an annual FASD Symposium for professionals and families.

The System of Care Project (commUNITY cares), now in its third year of implementation and serving youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar counties, has held several workshops specifically addressing topics such as cognitive behavioral therapy techniques, strengths-based wraparound approaches, and implementation of the Seven Challenges program. The Annual Mississippi School for Addiction Professionals and the annual Lookin' to the Future Conference provides sessions on youth with co-occurring disorders.

DMH continues to provide funding to two community based residential treatment programs, which make available 48 beds for chemical dependence residential treatment for adolescents, some of whom also have a serious emotional disturbance.

The Bureau of Alcohol and Drug Abuse and the Bureau of Community Services have an ongoing collaboration to continue to provide treatment services for adults with both mental illness and substance abuse disorders, participate in joint education and training initiatives and conduct monitoring of programs throughout the state. The DMH received funding from CMHS for the Transformation Transfer Initiative (TTI), one component of which was designed to support continued training of mental health providers in assessment and treatment of co-occurring disorders. Coaching and technical assistance were also offered to all 15 regional community mental health centers and to four state hospitals following the training.

Priority 7: Integration of Behavioral Health and Primary Care Services (Combined – SMHA/SSA)

The DMH envisions a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports. DMH is committed to maintaining a statewide comprehensive system of prevention, treatment and rehabilitation which promotes quality care, cost effective services and ensures the health and welfare of individuals.

The FY 2012-*2013* State Plans for Community Mental Health and Alcohol and Drug Abuse reflect the elements in the Department of Mental Health's Ten-Year Strategic Plan which encompasses Integration of Behavioral Health and Primary Care Services, Recovery Supports and Provision of Services for Individuals with Co-Occurring Disorders.

Strategies designed to facilitate integration of mental illness and substance abuse are included the Department's Plan (objectives to increase integration of primary and mental health care and to increase effectiveness of collaboration among community mental health providers, state agencies, governmental entities and non-governmental entities). In July 2011, staff from DMH, Bureau of Community Services attended the Improving Access and Quality Care for the Behavioral Health Client Conference in Atlanta, and interacted with staff from the Mississippi Primary Health Care Association. DMH staff has been invited to present on the DMH and CMHCs at a conference sponsored by the Mississippi Primary Health Care Association in September 2011. Dr. Lydia Weisser, the DMH Medical Director, serves as the DMH "content expert" on primary care and behavioral health integration.

Examples of current collaborative activities involving mental health and/or substance abuse, primary health and other support service providers include:

- A representative from Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) teams across the state.
- As part of their application to DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services.
- The DMH Division of Consumer and Family Affairs is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers.
- The DMH Division of Alzheimer's Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.
- The DMH Bureau of Alcohol and Drug Abuse continues to work with the Attorney General's Office in enforcement of the state status prohibiting the sale of tobacco

products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner.

- The DMH Bureau of Alcohol and Drug Abuse partners with the MS Department of Rehabilitation Services to fund substance abuse treatment services to individuals in transitional residential programs.
- The DMH Bureau of Alcohol and Drug Abuse works collaboratively with the MS Band of Choctaw Indians and continues to fund prevention services with Choctaw Behavioral Health.
- DMH funds Region 4 and Region 8 CMHCs to provide therapeutic nursing services in the schools, which include services such as providing education for children/youth with SED, their families and teachers, conducting physical observations and assessments**,** providing information about and monitoring medications, monitoring sleeping and eating habits, and assisting with health objectives on treatment plans, etc.

Priority 8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

An adult with a serious mental illness is defined as any individual, age 18 or older, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills.

The majority of the public community mental health services for adults with serious mental illness in Mississippi is provided through 15 regional mental health/mental retardation commissions, which operate 15 regional community mental health centers serving all 82 counties of the state. The mental health centers are governed by regional commissions, with representative commissioners for each county in the region appointed by county Boards of Supervisors. As described in more detail in the Section I, the Mississippi Department of Mental Health sets and monitors implementation of minimum standards for community mental health programs certified through the authority of the DMH. Implementation of these standards, which establish minimum requirements for programs in organization, management and in specific services, is monitored through on-site visits of programs throughout the year by DMH staff. Some community services (such as case management, psychosocial rehabilitation, group homes and supervised apartments and specialized programs for homeless persons with mental illness) are also provided to some individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These services are primarily for individuals discharged from the hospital and are in the areas in close proximity to the hospitals (Jackson and Meridian). These programs are also monitored for implementation of minimum standards applicable to the community mental health programs they provide. Community mental health centers provide pre-evaluation screening for individuals referred for evaluation for commitment to the state inpatient facilities**,** which provide regionalized, inpatient services.

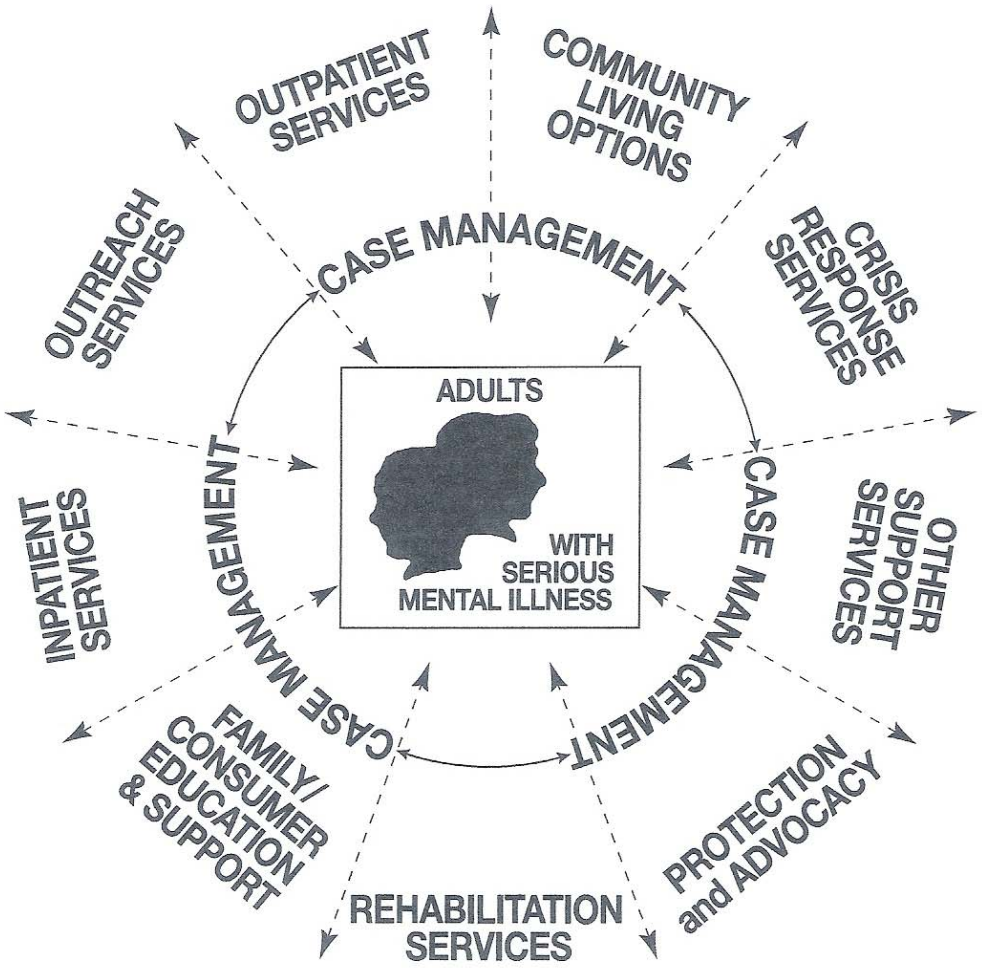
Ideal System Model

The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness was developed to reflect an ideal system that is responsive to the strengths and needs of all individuals with serious mental illness. At the center of the system is the person, each with his or her individual strengths and needs, which vary across time and circumstances. Revolving around the person and between the person and his or her family and

components of the mental health and support system, is case management. Case management is the key to accessing and coordinating mental health and support services needed by the individual at any given time. In the ideal system, the case manager continually works with the individual to aid in identifying that person's goals, helping them to recognize strengths and barriers, and in developing and implementing an action plan based on identified needs. The Ideal System Model for Adults emphasizes a psychosocial rehabilitation approach to making an array of appropriate mental health, social, vocational, educational, and other support options available, based on individuals' strengths, as well as their needs. Several types of service options and activities may be included in the service components of the Ideal System Model. A major change in the description of the characteristics of the system has been made to reflect a philosophy shift to one that is more person-directed and thus, individualized. Strategies to evaluate and improve the effectiveness of local advisory councils, which include consumers and family members, have been included in system improvement efforts. The major service components of the Ideal System Model for Adults include: case management, outpatient services, crisis response services, alternative living arrangements (housing), identification and outreach, psychosocial rehabilitation services, family/consumer education and support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance abuse are also included in the system of community-based care.

IDEAL SYSTEM MODEL

Mississippi Comprehensive Community Mental Health System
for
Adults With Serious Mental Illness



CHARACTERISTICS OF THE SYSTEM

- Person - Directed
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- Emphasis on Recovery

Priority 9: Targeted Services to Rural and Homeless Adults with SMI

The DMH continues to support specialized services targeting individuals who are homeless and have mental illness in areas of the state where there are known to be large homeless populations with a significant number of individuals with mental illness and where the (Projects for Assistance in Transition from Homelessness or PATH) funds would have the greatest impact – Jackson, Meridian and the Gulf Coast. In April 2011 the DMH added a sixth PATH Provider, Mississippi United To End Homelessness (MUTEH), which currently serves as the Balance of State Continuum of Care for Mississippi. MUTEH's service area includes all counties not already being served by the existing PATH Programs.

The DMH Division of Community Services staff member, who oversees the administration of the PATH grant program in MS, served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area. DMH staff also continued to attend meetings of MISSIONLinks, which is an alliance of emergency and transitional shelter operators and mental health service providers.

Additionally, the Division of Community Services staff member working on housing issues for individuals with serious mental illness who are not necessarily homeless, also attends meetings of the Partners to End Homelessness to facilitate coordination of planning.

In 2010 the DMH received notification that its application for Technical Assistance training in the SSI/SSDI Outreach, Access and Recovery (SOAR) Program offered through SAMSHA was approved. The SOAR Project helps states increase access to mainstream benefits for people who are homeless or at risk of homelessness through training, technical assistance and strategic planning. Since approval of Mississippi's SOAR application, four individuals have attended the SAMHSA-sponsored SOAR Train-the-Trainer program, and became Certified SOAR Trainers. In March of 2011 a two-day SOAR Training was conducted and other training events will be conducted in the future.

Community mental health centers will continue to be required to develop plans for outreach, including transportation, as part of their community support services plans approved by the DMH. The Mississippi Transportation Coalition, which includes representation from the DMH, continues to meet monthly to address coordinated planning for transportation. In FY 2010, the DMH received Transformation Transfer Initiative (TTI) funding from the Center for Mental Health Services, one component of which will enhance the coordination of transportation services and service providers. DMH will also utilize grant funds to pay for transportation for individuals with disabilities. In FY 2011, DMH continues to work on a pilot project in the Region 6 CMHC catchment area. It is anticipated, that after 100 transportation needs assessments have been conducted, a local transportation provider will begin a call-in center. This call-in center will provide rides for individuals with disabilities at a reduced rate. It is our hope to replicate this pilot project statewide when funding is available.

Priority 10: Management Systems

Management goals that apply to both child and adult service systems for improving information management systems, to continue helpline services through the Office of Consumer Support

Services, and to request additional funding for community mental health services address this priority. See also Tables 5-8 for financial information, as well as Section E. Data and Information Technology, F. Quality Improvement Reporting, and H. Service Management Strategies for additional information on management systems.

Step 4: Goals/objectives, Strategies and Performance Indicators for Children with Serious Emotional Disturbance (SED) and their Families

State Priority #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue availability of funding for two prevention/specialized early intervention programs.

Strategy: DMH will continue to provide funding for two prevention/specialized early intervention programs for **c**hildren/youth with SED identified by this program. These children/youth receive prompt evaluation and referrals, and appropriate therapeutic intervention to address the abuse; parents receive effective parenting skills training and family interventions, as well as other interventions designed to reunify and/or improve family relationships where possible.

Performance Indicator: The number of programs to which DMH makes available funding to help support prevention/early intervention (two)

Description of Collecting and Measuring Changes in Performance Indicator:
DMH RFPs/grant applications/grants

***Footnote:** Prevention services supported through state funds from DMH and provided to these families include home visits, prenatal education, parenting education classes, preschool classes, sibling intervention groups, and specialized multidisciplinary sexual abuse prevention programs. The DMH also has a representative on the State Board for the Children's Trust Fund, which support projects across the state and provides financial assistance for direct services to prevent child abuse and neglect and to promote a system of services, laws, practices and attitudes that enable families to provide a safe and healthy environment for their children.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue to provide technical assistance through the Division of Children and Youth Services to encourage providers to make children's mental health services available to serve children with SED under the age of six years with

emphasis on those children who screen positive for prenatal exposure to alcohol.

Strategy: Technical assistance will be provided by the Division of Children and Youth Services staff, upon request, including on-site visits, to providers interested in developing children's mental health services to serve children with SED under the age of six years.

Performance Indicator: DMH Division of Children and Youth Services staff will provide technical assistance to service providers on developing mental health services for children under six years of age

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Division of Children and Youth Services monthly staffing report forms

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue availability of school-based general outpatient mental health services (other than day treatment).

Strategy: Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families. Current DMH Operational Standards require all CMHCs to offer and if accepted, maintain interagency agreements with each local school district in their region, which outline the provision of school-based services to be provided by the CMHCs.

Performance Indicator: Number of regional community mental health centers through which general outpatient services for children with serious emotional disturbance are made available (offered) to schools (Offered by 15 CMHC Regions).

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Division of Children and Youth Services records/reporting; Annual State Plan Survey

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue to make available funding for respite service capabilities.

Strategy: DMH will continue to fund two providers to support the implementation of respite services, which are planned temporary services provided for a period of time ranging from a few hours within a 24-hour period, to an overnight or weekend stay. Respite is a service identified by families and representatives of state child service agencies, as well as other stakeholders, as a high need service for families and children with SED to support keeping youth in the home and community.

Performance Indicator: The number of respite providers available during the year (200)

Description of Collecting and Measuring Changes in Performance Indicator: Annual State Plan Survey

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue to provide DMH funding to assist in providing therapeutic foster care homes to serve children/youth with SED to further develop community-based residential mental health treatment services for children with SED.

Strategy: DMH will continue to provide funding to the evidence-based therapeutic foster care program operated by Catholic Charities, Inc. The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by DMH.

Performance Indicator: The number of children receiving therapeutic foster care services, based on evidence-based practice, provided with DMH funding support (i.e., through Catholic Charities, Inc.)

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Program grant reports

***Footnote:** Therapeutic Foster Care (TFC) Services continue to be an important community-based component, particularly for children with serious emotional disturbance in the custody of the Department of Human Services. The model utilized in Mississippi employs trained therapeutic foster parents with only one child or youth with SED placed in each home. DMH continues to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. Additional youth are served in therapeutic foster care funded by other agencies, including the Department of Human Services. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 211 youth in FY 2010.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: DMH funding will continue to be made available for nine therapeutic group homes for children and youth with serious emotional disturbance.

Strategy: DMH will continue to provide funding to support therapeutic group homes. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

Performance Indicator: The number of therapeutic group homes for which the

DMH provides funding support (nine)

Description of Collecting and Measuring Changes in Performance Indicator:
Division of Children/Youth Services Residential Monthly Summary Forms/Grant Proposals from the existing DMH-funded therapeutic group home providers

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue support and funding for existing programs serving children who are homeless/potentially homeless due to domestic violence or abuse /neglect.

Strategy: DMH will continue to provide funding and support for two specialized programs serving homeless children/youth with SED who are homeless/potentially homeless due to domestic violence or abuse /neglect.

Performance Indicator: Availability of DMH funding for two specialized programs serving homeless children/youth with SED who are homeless/potentially homeless due to domestic violence or abuse /neglect.

Description of Collecting and Measuring Changes in Performance Indicator:
Division of Children/Youth Services Program grant reports.

* **Footnote:** Additionally, from a system perspective, the number of youth reported as homeless/in shelters as a percentage of youth served in the public community mental health system through aggregate reports from DMH funded/certified providers in the Uniform Reporting System (URS) will also be reviewed.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To evaluate children with serious emotional disturbance who receive substantial public assistance for the need for case management services and to offer case management services for such families who accept case management services.

Strategy: Evaluation services will be provided to determine the need for case management, as documented in the record, for children with serious emotional disturbance who are receiving Medicaid and are served through the public community mental health system. School Based Services (Consultation and Crisis Intervention), Mental Illness Management Services (MIMS) and Individual Therapeutic Support are case management services that are available for children with serious emotional disturbances.

Performance Indicator: Number of children with serious emotional disturbances who receive case management services (26,250)

Description of Collecting and Measuring Changes in Performance Indicator:

Compliance will be monitored through the established on-site review/monitoring process

***Footnote:** The following children/youth with serious emotional disturbances must be evaluated for the need for case management and provided with case management if needed, based on evaluation, unless the service has been rejected in writing by the parent(s)/legal guardian(s): children/youth with SED who receive substantial public assistance; children/youth with SED who are receiving intensive crisis intervention services; and, children/youth referred (within two weeks) to the CMHC after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue to make funding available for five comprehensive crisis response programs for youth with serious emotional disturbance or behavioral disorder who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement.

Strategy: DMH will continue funding to implement comprehensive intensive crisis response programs for youth with serious emotional disturbance or behavioral disorders that are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement.

Performance Indicator: Number of comprehensive crisis response programs for which DMH provides funding (five)

Description of Collecting and Measuring Changes in Performance Indicator:
Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for four comprehensive crisis response programs.

***Footnote:** All five non-profit providers of comprehensive crisis intervention programs are affiliated with their local Making a Plan (MAP) teams.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue specialized outpatient intensive crisis intervention capabilities of five projects.

Strategy: DMH will continue funding specialized outpatient intensive crisis projects (five)

Performance Indicator: The number of programs that receive DMH funding for specialized outpatient intensive crisis intervention projects (five)

Description of Collecting and Measuring Changes in Performance Indicator:

Division of Children/Youth Services Crisis Monthly Summary Forms/Grant Proposals for the specialized programs/monthly cash requests.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To maintain provision of community-based services to children with serious emotional disturbance.

Strategy: DMH will continue to collect data on the total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers.

Performance Indicator: The total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance (52,500). It should be noted that the number of youth targeted to be served in the following objective includes only youth with serious emotional disturbances served through the public community mental health system, which are a subset of the number of youth with any mental illness accessing services in the public community and inpatient system, reported in the NOM.

Description of Collecting and Measuring Changes in Performance Indicator:

Annual State Plan survey; community mental health service provider data.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To improve school attendance for those children and families served by CMHCs.

Strategy: School-based therapists employed by the CMHCs will continue to offer and provide as requested mental health services in the local schools, including school-based outpatient and school-based day treatment programs as described in the State Plan.

Performance Indicator: Interagency agreements between schools and CMHCs providing school-based Services will be verified on monitoring visits by DMH.

Description of Collecting and Measuring Changes in Performance Indicator:
Interagency agreements between schools and CMHCs providing school-based services; site visit documentation.

***Footnote:** A major area of growth in the system of care has been the development through community mental health centers of school-based outpatient sites and day treatment statewide, which is also the primary strategy for increasing accessibility of services for youth in rural areas. From a system perspective Uniform Reporting System (URS) data on changes in school attendance reported by family members/caregivers (based on results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving

services in the public community mental health system (funded and certified by DMH) will also be reviewed.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue funding to an existing program serving children who are homeless/potentially homeless due to domestic violence.

Strategy: DMH will continue to provide funding to a Women's Center for Nonviolence to be made available for crisis intervention services to children and families in a domestic violence situation. Funding provides intensive crisis intervention and support services with an emergency shelter for abused/neglected children/youth and training to staff of the shelter. Gulf Coast Mental Health Center, provides consultation and in-service training to the shelter staff, crisis intervention available on a 24-hour basis, individual, group and family therapy to the children admitted to the shelter.

Performance Indicator: The number of children served through this specialized program (175)

Description of Collecting and Measuring Changes in Performance Indicator: Grant proposal for existing program. This children's program is required to submit monthly data on the number of children served (targeted above) including the number of children with serious emotional disturbance.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue funding to one CMHC for provision of intensive crisis intervention services to youth/families served through a shelter for abused/neglected children.

Strategy: DMH will continue to provide funding to support a CMHC in providing crisis intervention services, a therapist and other needed supports to a local shelter for abused/neglected children.

Performance Indicator: The number of children served through this specialized program (437)

Description of Collecting and Measuring Changes in Performance Indicator: Grant proposal for the targeted CMHC

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To continue to make available technical assistance and/or certification visits in expanding school-based children's mental health services.

Strategy: DMH Division of Children and Youth Services will continue to provide technical assistance regarding the availability of and access to school-based services across CMHC regions. DMH will continue efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas.

Performance Indicator: Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools (15)

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report

***Footnote:** Key to the Department of Mental Health's approach to increasing the accessibility of children's mental health services in rural areas has been expansion of school-based services. Using the school as a base for mental health service delivery is pivotal in facilitating access to services by many youth and families. Providing school-based services also helps address the problem of transportation that exists in rural and other parts of the state.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED.

This goal also addresses Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To further enhance service development and quality of service delivery to minority populations of children and youth with severe behavioral and emotional disorders.

Strategy: DMH requires CMHCs and other DMH-certified programs to offer cultural diversity and/or sensitivity training to employees, in accordance with DMH Operational Standards.

Performance Indicator: Number of training sessions presented for children/youth service providers that address cultural diversity awareness and/or sensitivity.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.

***Footnote:** Division of Children and Youth staff members have attended workshops on Disparities Among Native Americans, Resources for Spanish-Speaking Communities, National Networks of Libraries of Medicine, Eliminating Mental Health Disparities: Challenges and Opportunities, and Lesbian, Gay, Bisexual and Transgender (LGBT) Youth in MS: Why Day of Silence Matters and African-American and LGBT conference.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children

and Youth with SED

See also Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal: To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force.

Strategy: Continued meetings/activity by the Multicultural Task Force. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas.

Performance Indicator: The number of meetings of the Multicultural Task Force during FY 2012 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council.

Description of Collecting and Measuring Changes in Performance Indicator:
Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made.

***Footnote:** The mission of the 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. There are 17 active members on the task force representing various state and local agencies and organizations . The task force has developed a cultural competency plan and has completed the Multicultural Competency Task Force Strategic Map and action plan for several of the strategic initiatives.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

See also Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal: To develop a committee to guide the implementation of the Cultural Competency Plan to ensure culturally competent services are provided to individuals receiving services.

Strategy: Develop a committee to guide the implementation of the Cultural Competency Plan.

Performance Indicator: Meeting/activity by the Cultural Competency Workgroup

Description of Collecting and Measuring Changes in Performance Indicator:
Minutes of the workgroup meetings

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

See also Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal: To expand the cultural competency assessment pilot project to include selected regions in the northern part of the state and additional areas in the central region.

Strategy: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project. Results from the administration of the cultural competence assessment will be available to be used by the CMHC/provider to determine areas of cultural competence that might need to be addressed.

Performance Indicator: The number of community mental health centers/providers that participate in the local cultural competency assessment project.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Activity Reports

***Footnote:** The Multicultural Task Force has also coordinated use of a cultural competence assessment instrument at the local level in Regions 1, 3, 4, 6, 7, 8, 11, 14 and 15 in previous years. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff has continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To maintain availability of technical assistance to all existing DMH-certified programs operated by the 15 community mental health centers and non-profit agencies in support of service development and implementation.

Strategy: DMH Division of Children and Youth Staff will continue to provide technical assistance to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.

Performance Indicator: The number and type of technical assistance/support activities made available to CMHCs/other nonprofit service providers.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children and Youth staffing report forms

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

See also Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal: To address the stigma associated with mental illness through a three-year anti-stigma campaign.

Strategy: DMH will continue to lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the anti-stigma campaign.

Performance Indicator: Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers (200,000). DMH will also track the number of live interviews and presentations.

Description of Collecting and Measuring Changes in Performance Indicator: Media and educational presentation tracking data maintained by DMH Director of Public Information.

***Footnote:** Since Oct. 1, 2009, a total of 104 *Think Again* and *Shatter the Silence* (anti-stigma/youth suicide prevention) presentations were conducted statewide reaching more than 3,200 individuals including 1100 youth in the public school system and 350 youth at the Native American Youth Conference. By utilizing media coverage and presentations, the *Think Again* campaign reached an audience of 1.5 million. DMH and the Think Again Network will be creating a website about mental health and suicide prevention devoted to teens/college students.

Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

See also Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal: To review CMHC Policy and Procedure Manuals to ensure adherences to the cultural and linguistic competency mandates required in the DMH Operational Standards and other mandates for federally funded programs**.**

Strategy: Review of the CMHC Policy and Procedure manual will provide an opportunity for CMHCs to develop and implement policies and procedures in the area of cultural and linguistic competence that will enhance service delivery for all. The DMH *Operational Standards for Community Mental Health/Mental Retardation Services* continue to require that all programs certified by DMH train newly hired staff in cultural diversity/sensitivity within 30 days of hire and annually thereafter. Compliance with standards continues to be monitored on site visits.

Performance Indicator: Staff in the Division of Children and Youth will review a minimum of five (5) CMHC Policy and Procedure Manuals per year.

Description of Collecting and Measuring Changes in Performance Indicator: A summary of the findings and additional development of polices and procedures will be generated.

State Priority #2: Interagency Collaboration for Children and Youth with SED

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To provide mental health representation on the executive level Interagency Coordination Council for Children and Youth (ICCCY) and the mid-management level Interagency System of Care Council (ISCC), as required by recent legislation.

Strategy: DMH will continue to be represented on the executive level ICCCY and the mid-level Interagency System of Care Council, in accordance with House Bill 1529 and continue participation in activities by both Councils to facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels)

Performance Indicator: Minutes of meetings and related documentation of attendance by DMH representatives at meetings scheduled in FY 2012 and FY 2013.

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of the ICCCY and the Division of Children and Youth Services Monthly Calendar and minutes of the mid-level Interagency System of Care Council and revised Interagency Agreement.

***Footnote:** Additional members added to the ICCCY include a representative from the Attorney General's office, a MAP Team Coordinator, a parent of youth with SED, a youth, child psychiatrist, a faculty member from the University of MS Medical Center, Director of the ARC of MS and an early childhood development expert.

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To continue operation of the State-Level Interagency Case Review/MAP Team for the most difficult to serve youth with serious emotional disturbance who need services of multiple agencies.

Strategy: The State-Level Interagency Planning and Case Review Team will continue to meet monthly to review cases and to address the needs of some youth with particularly severe or complex issues. The team targets those "most difficult to serve" 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 (in-state) or out-of-state placement. The youth reviewed by the team typically have a history of more

than one out-of-home psychiatric treatment and appear to have exhausted all available services/resources in the community and/or in the state. The team develops a recommended resource identification and accessibility plan, which might include formal existing services and informal supports; monitors and tracks implementation of the recommended service plan and the status of the child/youth; and, uses information about the availability of needed services, success of services, and other pertinent information in planning efforts.

Performance Indicator: Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report and State Level Case Review Team Staffing forms.

***Footnote:** The State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, includes representatives of key child service agencies or programs and of families of children with serious emotional disturbance.

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To provide funding for the State-Level Interagency Case Review/MAP Team to purchase critical services and/or supports identified as needed for targeted children/youth with SED reviewed by the team.

Strategy: DMH Division of Children and Youth Services will make funding available to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team**.** The state-level team facilitates a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home. Youth from communities in which there is no local MAP team with funding have priority.

Performance Indicator: Number of children served using this funding for wraparound services

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of grant award on file at DMH; monthly cash requests.

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To continue to provide support and technical assistance in the implementation of Making A Plan (MAP) teams and to further assist in the wrap-around approach to provide services and supports for children/youth with SED and their families.

Strategy: DMH Division of Children and Youth Services will continue to provide support and technical assistance to MAP Teams as requested and/or needed and will **c**ontinue to coordinate meetings with MAP team coordinators to which representatives from the state hospitals child/adolescent units and the Department of Human Services representatives are invited.

Performance Indicator: Provision of MAP team local coordinators meetings for

networking among MAP teams. Number of technical assistance visits by Division of Children and Youth staff.

Description of Collecting and Measuring Changes in Performance Indicator:
Monthly Division Activities Report and minutes of local MAP team meeting.

***Footnote:** The MAP teams employ a systems-based wraparound approach in developing a family-centered multi-disciplinary plan, designed to address individual needs and build on the strengths of youth and their families. 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 human services (family and children's social services) staff, county youth services (juvenile justice) staff, county health department staff, county rehabilitation services staff and local school staff. Other providers of formal or informal supports, such as youth leaders, ministers or other representatives of children/youth family service organizations in a given community, may also participate in the planning or service implementation process.

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To continue to make available funding for Making A Plan (MAP) Teams

Strategy: DMH will continue to fund MAP Teams

Performance Indicator: Number of MAP teams that receive or have access to flexible funding through DMH (52)

Description of Collecting and Measuring Changes in Performance Indicator:
Documentation of grant awards; Monthly MAP team reports; monthly cash requests.

***Footnote:** Fifty-two counties either have a MAP Team or access to one, and all 40 MAP Teams continued to operate statewide and had accessibility to flexible funds.

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To continue to provide information to schools on recognizing those children and youth most at risk for having a serious emotional disturbance or mental illness and on resources available across the state, including services provided by CMHCs.

Strategy: DMH will make available informational materials and technical assistance to local school districts and other individuals/entities by CMHCs, upon request.

Performance Indicator: The number of local schools to which the CMHCs make available informational materials or technical assistance will be documented/ available to the DMH, Division of Children/Youth, upon request.

Description of Collecting and Measuring Changes in Performance Indicator:

Annual State Plan Survey

Priority Area #2: Interagency Collaboration for Children and Youth with SED

Goal: To continue support for and participation in interagency collaboration activities and other key activities related to infrastructure building as well as to make available technical assistance for this development at the state and local levels.

Strategy: DMH Children and Youth Services staff will continue to participate on state-level interagency councils or committees. Interagency collaboration at the state and local levels in planning and training is necessary to develop a more integrated system and to improve continuity of care.

Performance Indicator: Number of state-level interagency councils/committees on which the DMH Division of Children and Youth Services staff participate.

Description of Collecting and Measuring Changes in Performance Indicator:
Monthly Division Activities Report

Priority Area #2: Interagency Collaboration for Children and Youth with SED
This goal also addresses Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To provide technical assistance to programs in the state serving children/youth with serious emotional disturbance

Strategy: The DMH Division of Children and Youth will provide information on applicable training/education opportunities to programs serving children/youth with serious emotional disturbance.

Performance Indicator: Number of technical assistance activities and/or training offered by DMH staff.

Description of Collecting and Measuring Changes in Performance Indicator:
Children and Youth Monthly Staffing Forms

Priority Area #3: Expansion of System of Care for Children and Youth with SED

Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To promote use of evidence-based practices in the community mental health services system for children with serious emotional disturbances

Strategy: The Division of Children and Youth Services will continue to provide technical assistance and to monitor therapeutic foster care programs certified, but not funded by the DMH.

Initiatives to promote implementation of other evidence-based practices for youth and families, such as the Learning Collaboratives for trauma-focused cognitive behavior therapy described in the Plan will also continue. Other local initiatives will also continue; for example, Region 12 CMHC and Region 13 CMHC have organized workforce training in trauma-focused CBT, CBT and Combined Parent Child CBT for all of their children's therapists, and evidence-based practices for youth are being implemented through the local System of Care project in Region 12.

Performance Indicator: The number of evidence-based practices implemented (with DMH funding support) for children with serious emotional disturbances.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Program grant reports.

Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To provide general information/education about children/adolescents "at risk" for or with serious emotional disturbance and about the system of care model (targeting the community at-large, as well as service providers).

Strategy: DMH will continue to make available current information about children's mental health services through printed material and education by DMH staff is a basic component of ongoing outreach services.

Performance Indicator: Continued production and dissemination of *the DMH Division of Children and Youth Resource Directory* and other relevant public education material, made available as needed. Participation in presentations by DMH Children and Youth Services staff at meetings at which public information is provided, as such opportunities are available.

Description of Collecting and Measuring Changes in Performance Indicator: Educational material dissemination documented on monthly staffing forms.

***Footnote:** The Children and Youth Services Directory is available through the DMH agency website. CYS resource directories are also disseminated at conferences or meetings or to individuals.

Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To address suicide awareness, prevention and intervention through training sessions or workshops focused on this topic.

Strategy: DMH staff will conduct training or workshops upon request by mental health centers, universities, community colleges and other community agencies.

Performance Indicator: The number of reports generated and distributed to DMH staff and the OCS Advisory Council (at least three quarterly reports and two annual reports and six presentations and/or workshops.

Description of Collecting and Measuring Changes in Performance Indicator:
Monthly Activity Reports Forms

***Footnote:** The MS Youth Suicide Prevention Council meets at least quarterly and provides leadership and perspective for statewide planning and implementation of prevention and early intervention strategies, including implementation of a Comprehensive State Plan for Youth Suicide Prevention.

Priority Area #3: Expansion of the System of Care for Children and Youth with SED

Goal: To co-sponsor statewide conferences and/or trainings on the System of Care for providers of mental health services, education services, rehabilitation, human services (child welfare), youth/juvenile justice, physical primary health, and families.

Strategy: DMH Division of Children and Youth will continue to provide support to statewide conferences and/or trainings for children's mental health service providers addressing system of care issues for participants from local and state child/family service agencies and families of children/youth with SED

Performance Indicator: The number of statewide conferences and/or trainings sponsored or co-sponsored by the Division of Children & Youth Services (six)

Description of Collecting and Measuring Changes in Performance Indicator:
Registration Forms for the Conferences; Final Conference Reports

Priority Area #3: Expansion of the System of Care for Children and Youth with SED

Goal: To expand evidenced-based skills training in trauma-informed services for children/youth with emotional disturbances

Strategy: DMH will continue to provide training for additional clinical staff in the evidence-based practice of trauma-focused cognitive behavior therapy through the learning collaborative model.

Performance Indicator: The number of additional community mental health services staff who complete training in trauma-focused cognitive behavioral therapy, SPARCS or other EPBs through Learning Collaboratives (90)

Description of Collecting and Measuring Changes in Performance Indicator:
Annual and information collected from TRY staff at Catholic Charities, Inc.

***Footnote:** The Director of the DMH Division of Children and Youth Services served in an advisory role to the Mississippi Trauma Recovery for Youth (TRY) project, funded through SAMHSA. Catholic Charities, Inc has led this four-year project. The conceptual framework of the project involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practice, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. The project also involves tracking of provision of services and treatment outcomes over a period of time.

Priority Area #3: Expansion of the System of Care for Children and Youth with SED

Goal: To implement the Wraparound Model in 7 of the 15 Community Mental Health Centers.

Strategy: DMH will continue to provide funds for training of additional CMHC staffing for a 3-day Wraparound 101 course, a one-day Advanced Wraparound course and a 12-18 month process for Coach/Supervisor Training utilizing staff from the University of Maryland's Innovations Institute. The Division of Children and Youth Services partners with the Division of Medicaid, MYPAC Program to provide state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers.

Performance Indicator: The number of community mental health centers participating in the Coach/Supervisor training and implementing the Wraparound model (7 CMHCs)

Description of Collecting and Measuring Changes in Performance Indicator:
Quarterly and mid-year information collected from CMHCs including sign-in sheets for trainings.

***Footnote:** The Division of Medicaid plans to include Wraparound facilitation in their submission to amend the State Medicaid Plan in FY 2012.

Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To expand specialized programs/resources for transition – aged youth, 16-21 years of age who are transitioning from child mental health services to adult mental health services and/or from an institutional setting into the community.

Strategy: The Division of Children and Youth Services received a state-wide Children's Mental Health Initiative (System of Care) grant on October 1, 2009 to serve transition-aged youth with SED. This initiative, the Mississippi Transitional Outreach Program (MTOP), is implemented in two Community Mental Health Centers. DMH will continue to fund these two local projects through 2015 and will add two more MTOP sites October 1, 2011.

Performance Indicator: The number of MTOP local project sites that will develop and provide specialized services/resources for youth and young adults, 16-21 years (four)

Description of Collecting and Measuring Changes in Performance Indicator:
DMH monthly program reports, national program and evaluation reports.

Priority Area #4: Integrated Services for Children and Youth with SED

Priority Area #4: Integrated Services for Children and Youth with SED

Goal: To reduce involvement of youth with serious emotional disturbances in the juvenile justice system**.**

Strategy: To continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by DMH. The Adolescent Offender Programs, which receive state funding through the Department of Human Services, Division of Youth Services, are designed to be a diversionary program from the state-operated training school. These programs target the areas of the state that have the highest commitment rates to the state training schools.

Performance Indicator: Availability of technical assistance to Adolescent Offender Programs.

Description of Collecting and Measuring Changes in Performance Indicator: Certification reports and Division of Children & Youth Services Monthly activity log (for technical assistance).

***Footnote**:* From a system perspective, Uniform Reporting System (URS) data (based on results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH) on the percentage of parents/caregivers of children/adolescents served by the public community mental health system reporting that their child had been arrested in one year, but was not rearrested in the next year, will also be reviewed**.**

Priority Area #4: Integrated Services for Children and Youth with SED

Goal: To continue funding for mental health services for youth in two transitional therapeutic group home**s** and two supported living programs for youth in the transition age group (16-21 years of age).

Strategy: DMH will continue funding two transitional living services group home**s** and two supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.

Performance Indicator: The number of transitional therapeutic group homes and/or supported living programs that will receive funding through DMH for mental health

service (four)

Description of Collecting and Measuring Changes in Performance Indicator: Grant awards to continue funding to the targeted transitional living services/supported living programs.

***Footnote:** The Transitional Services Task Force assisted in the development of a successful grant application for a Children's Mental Health Initiative targeting transition – aged youth. The six-year System of Care grant provides funds for the implementation of four additional Transitional Outreach Programs (TOP) across the state.

State Priority #5: Recovery Supports (Combined – SMHA/SSA)

Priority Area #5: Recovery Supports – Children and Youth

Goal: To continue to make available funding for family education and family support capabilities.

Strategy: Continuation of funding for family education and family support will be made available by DMH for two Youth Leadership Teams (both affiliated with CMHS initiative, National Youth MOVE) and a Youth Summer Day Camp coordinated by Mississippi Families As Allies (MS FAA).

Performance Indicator: Number of family workshops and training opportunities to be provided and/or sponsored by MS FAA (42)

Description of Collecting and Measuring Changes in Performance Indicator:
Grant awards/monthly cash requests from MS Families As Allies for Children's Mental Health, Inc., MS NAMI, and Region 10 CMHC.

Priority Area #5: Recovery Supports (Combined-SMHA/SSA)

Goal: To develop youth support and leadership teams in the current two project sites for the Mississippi Transitional Outreach Program (MTOP)

Strategy: Continue to support and fund the development of youth support and leadership teams in CMHC Regions 4 and 7.

Performance Indicator: A regular schedule and agenda of the meetings will be available during the year for CMHC Regions 4 and 7.

Description of Collecting and Measuring Changes in Performance Indicator:
The schedules and agenda are provided by the local project coordinators.

Priority Area #5: Recovery Supports (Combined-SMHA/SSA)

Goal: To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health and substance abuse services.

Strategy: DMH will continue to refine the peer review/quality assurance process for all community mental health programs and services, including substance abuse services, by utilizing the Personal Outcome Measures (POM) interview protocol to measure outcomes of individuals receiving services. Consumer and family member meaningful involvement will be present on all levels of decision-making in policy development, planning, oversight, and evaluation.

Performance Indicator: Improved access and outcomes of services to individuals receiving services will be reported; Number of consumers and family members involved in decision-making activities, peer review/site visits.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH data.

Priority Area #5: Recovery Supports (Combined-SMHA/SSA)

Goal: To promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services.

Strategy: Increase staff, consumers and their families understanding of topics related to recovery/recovery supports; the DMH Bureaus/Divisions will partner to plan resource/health fairs to educate others about recovery; information about the Mississippi Leadership Academy (MLA) will be made available to consumers with serious mental illness to increase communication and leadership/advocacy skills; continued funding will be made available by DMH for family education and family support programs/activities (drop-in centers, NAMI, MLA); and DMH will promote consumer information sharing and exchange through the MS Mental Health Recovery Social Network website

Performance Indicator: Number of family education groups and number of family workshops and training opportunities to be provided; number of consumers/family members completing the MLA; list of MH/SA trainings/participation summary of meetings and conferences provided by prevention and mental health staff; quarterly distribution of materials and resources will be tracked; and use and satisfaction of website services will be tracked.

Description of Collecting and Measuring Changes in Performance Indicator:
Grant awards/monthly cash requests from service providers will be tracked; documentation/dates of material provided; and MLA activities will be reported monthly

Priority Area #5: Recovery Supports (Combined-SMHA/SSA)

Goal: To establish policies and procedures to ensure consumer and family participation in monitoring/evaluating the mental health system through the peer review process.

Strategy: DMH Bureaus and Divisions will develop policies and procedures for the peer review process.

Performance Indicator: Increased number of consumers and family members involved in decision-making activities, peer review/site visits

Description of Collecting and Measuring Changes in Performance Indicator:
DMH will utilize the Council on Quality and Leadership's (CQL) Personal Outcome Measures (POM) tool to gain information about the level at which service providers are supporting personal outcomes of individuals being served. Policies and procedures and number of POM interviews conducted by consumers and family members will be tracked

State Priority #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined – SMHA/SSA)

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders.

This goal also addresses Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: To provide funding and support of a System of Care Project that targets children/youth 10-18 years old with co-occurring disorders in three counties in the State.

Strategy: The Division of Children and Youth will continue to provide state match and funding for commUNITY cares, a System of Care Project in Forrest, Lamar, and Marion Counties and will continue to support and participate in commUNITY cares activities and committees.

Performance Indicator: The number of youth served and funding amounts. The number of activities and committees in which Division of Children and Youth Staff participate monthly.

Description of Collecting and Measuring Changes in Performance Indicator: DMH Division of Children and Youth Services monthly staff forms, commUNITY cares monthly service reports, grant proposals from continuation of SOC, and Division of Children and Youth program grant files.

***Footnote:** Division of Children and Youth staff continues to monitor and provide technical assistance two programs, the ARK and Sunflower Landing, serving youth with co-occurring disorders. Staff in both the DMH Bureau of Alcohol and Drug Abuse and the Division of Children and Youth Services have provided training, information and support to women who may be pregnant or may have children with them while receiving

treatment in one of the adult substance abuse residential treatment facilities. DMH co-sponsors two conferences that provide sessions on youth with co-occurring disorders, the Annual Mississippi School for Addiction Professionals and the Annual Lookin' To The Future Conference.

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders.

This goal also addresses Priority Area #3: Expansion of System of Care for Children and Youth with SED

Goal: The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned for FY 2012

Strategy: Division of Children and Youth Services staff members will continue to collaborate with the Bureau of Alcohol and Drug Abuse to develop a workshop focusing on youth with co-occurring disorders for the upcoming System of Care and/or the Mississippi School for Addiction Professionals

Performance Indicator: Inclusion of a workshop focusing on identification and/or treatment of youth with co-occurring disorders of serious emotional disturbance and substance abuse in a statewide conference

Description of Collecting and Measuring Changes in Performance Indicator:
Conference program(s)

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Children and Youth)

Goal: To provide funding to maintain 48 beds in community-based residential treatment services for adolescents with substance abuse problems and co-occurring disorders.

Strategy: Division of Children and Youth services will provide funding to two community-based residential treatment program services and beds for adolescents with substance abuse problems and co-occurring disorders. Services provided include individual counseling, psychotherapeutic group counseling, self-help groups, family counseling, education services dealing with substance abuse and addiction, educational programs at the appropriate academic levels, vocational counseling services, and recreational and social activities.

Performance Indicator: Number of beds available in community-based residential treatment programs for adolescents with substance abuse problems that receive funds from DMH (48)

Description of Collecting and Measuring Changes in Performance Indicator:
Division of Children/Youth Services Residential Monthly Summary Form/Grant Proposals for two community-based residential treatment sites.

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To promote the concepts of recovery and person-centeredness into services for individuals with co-occurring disorders.

Strategy: DMH will provide state-wide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values.

Performance Indicator: Improved outcomes of individuals receiving services will be reported; increased access to community based supports will be reported; increased knowledge of staff will be reported; and increased number of positive responses to the Council on Quality and Leadership's (CQL) 21 Personal Outcome Measures (POM)©

Description of Collecting and Measuring Changes in Performance Indicator:
POM interviews

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To expand and improve integrated treatment service options for individuals with co-occurring disorders.

Strategy: DMH will review alternative funding to provide additional training on COD; DMH will coordinate and partner with other agencies and organizations to provide and attend COD training; and DMH will continue to monitor and review services provided by the 15 mental health regions and Mississippi State Hospital.

Performance Indicator: Number of COD trainings provided and attended and number of COD programs reviewed

Description of Collecting and Measuring Changes in Performance Indicator:
Sign in sheets, agendas, and program monitoring schedules

Priority Area #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To further develop the linkage between the Bureau of Alcohol and Drug Abuse and the Bureau of Community Services regarding COD's in individuals with SED, FASD, SMI and Substance Abuse.

Strategy: Both Bureaus will collaborate in a state-wide conference planned for FY 2012 (MS School for Addiction Professionals), and both Bureaus will continue to monitor and provide technical assistance to co-occurring programs upon request.

Performance Indicator: Number of technical assistance and certification visits by DMH staff to programs implementing and/or planning programs to serve individuals with co-occurring disorders will be tracked; conference planning minutes and conference agenda; and Division of Children and Youth Monthly Reporting Form to track technical assistance provided

Description of Collecting and Measuring Changes in Performance Indicator:
Conference program, sign in sheets, agendas, and program monitoring schedules

Priority #6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Adult)

Goal: To provide community-based residential treatment services to individuals with co-occurring disorders will continue in on site

Strategy: Continued operation of a residential treatment service for individuals with co-occurring disorders of serious mental illness and substance abuse. Funds will be provided to continue support for operation of a 12-bed community-based residential facility for individuals with a co-occurring disorder operated by the Division of Community Services of Mississippi State Hospital.

Performance Indicator: The number of community residential treatment beds to be made available (12 beds)

Description of Collecting and Measuring Changes in Performance Indicator: The number of community residential treatment beds to be made available (12 beds)

Priority Area #6: **Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Adult)**

Goal: To continue to provide community services to individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

Strategy: DMH will continue to provide community services to individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

Performance Indicator: All 15 CMHCs and the community services division of Mississippi State Hospital will provide services to individuals with co-occurring disorders.

Description of Collecting and Measuring Changes in Performance Indicator: The number of individuals with co-occurring disorders to be served.

State Priority #7: Integration of Behavioral Health and Primary Care Services

Priority Area #7: Integration of Behavioral Health and Primary Care Services (Children and Youth)

Goal: To provide support for registered nurses to address physical/medical needs of children with SED in one rural, one mixed rural/urban area of the state

Strategy: Continue to fund targeted community mental health regions to provide ongoing therapeutic nursing services to children with SED, which include providing education for children/youth with SED, their families and teachers, conducting physical observations and assessments, providing information about and monitoring medications, monitoring sleeping and eating habits, and assisting with health objectives on treatment plans, etc. Designated Division of Children and Youth staff will continue to provide technical assistance to the CMHC providing these nursing services and monitors the delivery of such services in accordance with requirements of the RFP.

Performance Indicator: The number of regions to which DMH will provide funding or intensive therapeutic nursing services for children with serious emotional disturbances (two)

Description of Collecting and Measuring Changes in Performance Indicator: Therapeutic nursing monthly summary form

Priority Area #7: Integration of Behavioral Health and Primary Health Care Services (Combined-SMHA/SSA)

Goal: Improve the coordination of services for all individuals across primary care and mental health systems through co-integration and collaboration with and among DMH Bureaus and Divisions, Primary Healthcare Providers (PHPs), consumers, family members, and other interested stakeholders.

Strategy: DMH Bureaus and Divisions (described in I.) will continue to develop and maintain partnerships with PHPs through a collaborative effort including, but not limited to, Making A Plan Teams (MAP), Case Managers, Substance Abuse Coordinators and Peer Specialists. DMH will open dialog with PHPs regarding how specific functions and services can be enhanced, blended, streamlined between Community Mental Health Centers (CMHCs) and PHPs. DMH will increase partnership activities between local entities and community providers such as hospitals, holding facilities, Crisis Stabilization Units, and CMHCs to establish triage, treatment, and diversion plans and to develop a plan for integrating mental illness, addiction, and Intellectual and Developmental Disabilities (IDD) services with primary health care.

Performance Indicator: List of PHPs in Mississippi for dissemination; Number of modifications in provider policies and procedures; monthly service reports; meeting minutes and attendance sheets; explore evidence-based practice (EBP) models related to successful integration; documentation of collaboration via grant planning meetings to acquire funding;

receipt of funding opportunities awarded to promote integration; development of a plan to integrate behavioral health and primary care services; number of MOUs developed with PHPs

Description of Collecting and Measuring Changes in Performance Indicator:
A record of dialog with PHPs will be established and maintained and documentation of outreach efforts and process for development of plan for integrating behavioral health and primary care services will be maintained.

Priority Area #7: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

Goal: FASD screening assessments will be made available in all 15 CMHC regions across the state, including MAP Teams, to determine the need for a diagnostic evaluation in children/youth (birth-18 years of age).

Strategy: Through a collaborative effort with University of Mississippi Medical Center Child Development Center (UMMCCDC), the DMH Operational Standards require children ages birth to age eighteen (18) be screened within six (6) months of Intake to determine the need for a FASD diagnostic evaluation for identification of primary health and behavioral health problems, and for intervention and treatment by behavioral and primary care providers in the local community. Local MAP Team Coordinators will coordinate the FASD screenings, referring children for diagnosis, and coordinating the provision of services. Case Managers at CMHCs implement interventions identified and assist in accessing needed primary care and behavioral health services.

Performance Indicator: Increased number of FASD screenings conducted by the CMHC and/or MAP Team (2,400); increased number of FASD diagnoses will be reported

Description of Collecting and Measuring Changes in Performance Indicator:
The number of FASD screenings conducted each year in or through the CMHCs and MAP Teams are counted on DMH Division of Children and Youth Monthly Service Report forms and MAP Team Referral reports and entered into a database at the DMH Division of Children and Youth.

Priority Area #7: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

Goal: To educate PHPs, consumers, family members, mental health/substance abuse providers and other workforce professionals on: 1) current issues and trends in alcohol, tobacco and other drug abuse (ATOD) prevention and 2) physical health topics affecting those with SMI, addiction and/or individuals with SMI and a co-occurring substance use disorder, and suicide prevention.

Strategy: Increase staff, consumers and their families understanding of health related topics and the connection between physical and behavioral health; the DMH Bureaus/Divisions will partner with PHPs to plan resource /health fairs; DMH will use web, print, social media, public

appearances, and the press to reach the general public, PHPs, mental health and substance abuse providers and other stakeholders in culturally and linguistically appropriate ways; DMH Bureaus and Divisions will provide substance abuse prevention and suicide prevention materials and resources to the MS Choctaw Tribal Schools in grades 7-12 on a quarterly basis; and the Bureau of Alcohol and Drug Abuse will educate PHPs on the prevention of ATOD

Performance Indicator: Educational materials disseminated to PHPs will be tracked; list of MH/SA trainings/participation by PHPs; list of PHP trainings/participation by MH/SA providers; summary of meetings and conferences provided by prevention and mental health staff; and quarterly distribution of materials and resources

Description of Collecting and Measuring Changes in Performance Indicator:
Documentation of materials and dates provided will be tracked. All resources and materials uploaded to the DMH website will be updated and tracked.

Goals/Objectives, Strategies and Performance Indicators for Adults with Serious Mental Illness (SMI)

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health services.

Strategy: DMH will continue to refine the peer review/quality assurance process for all adult community mental health programs and services based on survey responses from community mental health center directors, peer reviewers, and interested stakeholders (i.e., NAMI-MS, MHA).

Performance Indicator: Improved access and outcomes of services to individuals receiving services will be reported. Number of consumers and family members involved in decision-making **a**ctivities, peer review/site visits.

Description of Collecting Changes in Performance Indicator: DMH data

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To make available funding to support an array of "Core" services to assist adults with serious mental illness.

Strategy: To provide grants, support and technical assistance to community providers that offer an array of community mental health services and supports. These services include:

Outpatient Services, a component of the ideal system, includes diagnostic and treatment services in various treatment modalities for persons requiring less intensive care than

inpatient services, including individuals with serious mental illness

Psychosocial rehabilitative services are therapeutic activity programs provided in the context of a therapeutic milieu in which consumers address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life.

Day Support is-a program of structured activities designed to support and enhance the functioning of consumers who are able to live fairly independently in the community through the regular provision of structured therapeutic support.

Acute Partial Hospitalization is a psychosocial rehabilitative service that is designed to provide an alternative to inpatient hospitalization or to serve as a bridge from inpatient to outpatient treatment

Group homes for adults with serious mental illness are homes shared by individuals in a community setting with 24-hour supervision. The program is designed to help individuals achieve more independence in a community living situation

Transitional Residential Treatment Services or Halfway Houses for adults with serious mental illness provide a comprehensive residential treatment program to persons with serious mental illness and are specifically designed to serve individuals who are at high risk of hospitali***zation***

Supervised housing is a form of housing service that provides a residence for three or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a group home

Supported living is programs designed to provide individuals some assistance while allowing them to maintain an independent residential arrangement *

Mental Illness Management Services (MIMS) include case management activities that may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the consumer live successfully in the community

Individual Therapeutic Support is the provision of one-on-one supervision of an individual with serious mental illness during a period of extreme crisis, without which hospitalization would be necessary.

Performance Indicator: The number of individuals served in the community will be tracked

Description of Collecting and Measuring Changes in Performance Indicator:
Documentation of grant award on file at DMH; monthly cash requests, satisfaction surveys.

***Footnote:** The DMH will continue to efforts to expand access and availability of housing options for individuals with serious mental illness, including acquiring sufficient staff time, training and resources to continue the development of service linkages with multiple housing partners at the state and regional levels and to identify support services and funding to sustain

individuals living in permanent supportive housing. Funding related to these efforts will be requested for FY 2013.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: Facilitate the employment of individuals with serious mental illness served by the public community mental health system**.**

Strategy: Continue to fund training to clubhouse programs in expansion of the TEP (transitional employment programs) and supported employment opportunities.

Performance Indicator: Availability of support for training programs in Strategy. See also description that follows.

Description of Collecting and Measuring Changes in Performance Indicator: Number of individuals engaged in TEP and supported employment, as documented by programs and monitoring on on-site certification visits. From a system perspective, the number of individuals employed (full- or part-time), including those in supported employment as a percentage of adults served by DMH certified and funded community mental health services. Aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS): Profile of Adult Clients by Employment Status will also be reviewed.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To provide resources and supports to allow adults with SMI to live in the community and reduce hospitalizations.

Strategy: To provide grants, supports, training and technical assistance to community providers to offer services that reduce hospitalization rates. Such services include:

Emergency Response/Crisis Management Services: The Department of Mental Health Operational Standards require that certified community mental health centers have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

Regional Acute Care/Crisis Stabilization System: The State Legislature funded major components to build a regional system to address the need for more immediate access to emergency or crisis services closer to consumers' home communities and their families, which will facilitate families' participation in consumers' treatment and transition from the hospital and reduce hospitalization and rehospitalization.

Efforts will also continue to maintain two PACT teams (in Regions 6 and 15).

Performance Indicator: Reduction in the number of admissions to state inpatient psychiatric facilities.

Description of Collecting and Measuring Changes in Performance Indicator:
Documentation of grant awards on file at DMH; monthly cash requests, satisfaction surveys, hospitalization intake numbers

***Footnote**: The Department of Mental Health remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Included in this array are services designed to divert hospitalization, and to address those factors determined to be associated most often with hospitalization or rehospitalization as well as to prevent inappropriate placement of individuals in jail.

Priority Area #8: Comprehensive Community Based Mental Health System for Adults.

Goal: To expand skills training to services providers in the provision of services for Adults with SMI.

Strategy: DMH will continue to provide training, support and technical assistance for staff working with adults with SMI, including the following programs:

The Case Management Certification Program has been modified and is now an internet-based staff training and development program. Elevate powered by Essential Learning is a customized training website that tracks staff training. The Essential Learning training website will take the place of case management orientation and eliminate the need for extensive travel for case managers to obtain training. Providing the case management training program online will provide cost savings to the state, as well as to service providers.

Pre-evaluation Screening for Civil Commitment Services is a major purpose of which is to reduce the number of inappropriate admissions to the state psychiatric facilities. DMH will continue to make available training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Operational Standards; a minimum of four training sessions per year will be provided.

Annual Conference on Alzheimer's Disease and Psychiatric Disorders in the Elderly:
A DMH Division of Community Services staff will continue to serve as a conference committee member to ensure that topics pertaining to psychiatric issues affecting elderly persons are addressed at the annual conference for persons with Alzheimer's Disease/Other Dementia.

Law Enforcement Training: DMH made funding available to 15 CMHCs to help support provision of law enforcement training. Twelve CMHCs applied for and received funding for law enforcement training. As of June 2011, CMHCs reported conducting 17 training sessions, with 446 law enforcement officers trained. This funding has been made available again in FY 2012, and 12 CMHCs have applied for and received the funding.

Performance Indicator: The number of community mental health services staff who receive training.

Description of Collecting and Measuring Changes in Performance Indicator:
Training documentation kept by DMH staff.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To provide community mental health and other support services for elderly persons with serious mental illness.

Strategy: Require a local plan from all 15 CMHCs for providing services to elderly persons with serious mental illness. The plan utilizes a guide that emphasizes outreach, interagency coordination of services and case management.

Performance Indicator: The number of CMHCs that submit a local plan for providing services to elderly persons with serious mental illness. (Minimum: 15)

Description of Collecting and Measuring Changes in Performance Indicator: Community Mental Health Center Local Plans for Elderly Services

Priority Area #8: **Comprehensive Community-Based Mental Health Systems for Adults**

Goal: To facilitate skills training for staff of senior psychosocial rehabilitation programs.

Strategy: DMH will continue to provide a one or two day training for staff in the senior psychosocial rehabilitation programs. There are currently three training sites. The training provides technical assistance.

Performance Indicator: The number of community mental health services staff who complete training for elderly psychosocial rehabilitation programs (training for 10 staff from elderly psychosocial rehabilitation programs).

Description of Collecting and Measuring Changes in Performance Indicator: Division of Community Services monthly grant report forms

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

See also Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To address the stigma associated with mental illness through a three-year anti-stigma campaign.

Strategy: DMH will continue to lead a statewide public education effort to counter

stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the anti-stigma campaign.

Performance Indicator: Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers (200,000). DMH will also track the number of live interviews and presentations.

Description of Collecting and Measuring Changes in Performance Indicator: Media and educational presentation tracking data maintained by DMH Director of Public Information.

***Footnote:** Since Oct. 1, 2009, a total of 104 *Think Again* and *Shatter the Silence* (anti-stigma/youth suicide prevention) presentations were conducted statewide reaching more than 3,200 individuals including 1100 youth in the public school system and 350 youth at the Native American Youth Conference. By utilizing media coverage and presentations, the *Think Again* campaign reached an audience of 1.5 million. DMH and the Think Again Network will be creating a website about mental health and suicide prevention devoted to teens/college students.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

See also Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force.

Strategy: Continued meetings/activity by the Multicultural Task Force. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas.

Performance Indicator: The number of meetings of the Multicultural Task Force during FY 2012 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council.

Description of Collecting and Measuring Changes in Performance Indicator:
Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made.

***Footnote:** The mission of the 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. There are 17 active members on the task force representing various state and local agencies and organizations. The task force has developed a cultural competency

plan and has completed the Multicultural Competency Task Force Strategic Map and action plan for several of the strategic initiatives.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

See also Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To develop a committee to guide the implementation of the Cultural Competency Plan to ensure culturally competent services are provided to individuals receiving services.

Strategy: Develop a committee to guide the implementation of the Cultural Competency Plan.

Performance Indicator: Meeting/activity by the Cultural Competency Workgroup

Description of Collecting and Measuring Changes in Performance Indicator:
Minutes of the workgroup meetings

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

See also Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To expand the cultural competency assessment pilot project to include selected regions in the northern part of the state and additional areas in the central region.

Strategy: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project. Results from the administration of the cultural competence assessment will be available to be used by the CMHC/provider to determine areas of cultural competence that might need to be addressed.

Performance Indicator: The number of community mental health centers/providers that participate in the local cultural competency assessment project.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Activity Reports

***Footnote:** The Multicultural Task Force has also coordinated use of a cultural competence assessment instrument at the local level in Regions 1, 3, 4, 6, 7, 8, 11, 14 and 15 in previous years. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff have continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults with SMI

See also Priority Area #1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: To review CMHC Policy and Procedure Manuals to ensure adherences to the cultural and linguistic competency mandates required in the DMH Operational Standards and other mandates for federally funded programs**.**

Strategy: Review of the CMHC Policy and Procedure manual will provide an opportunity for CMHCs to develop and implement policies and procedures in the area of cultural and linguistic competence that will enhance service delivery for all. The DMH *Operational Standards for Community Mental Health/Mental Retardation Services* continue to require that all programs certified by DMH train newly hired staff in cultural diversity/sensitivity within 30 days of hire and annually thereafter. Compliance with standards continues to be monitored on site visits.

Performance Indicator: Staff in the Division of Community Services will review a minimum of five (5) CMHC Policy and Procedure Manuals per year.

Description of Collecting and Measuring Changes in Performance Indicator: A summary of the findings and additional development of polices and procedures will be generated.

State Priority #9: Targeted Services to Rural and Homeless Adults with SMI

Priority Area #9: Targeted Services to Rural and Homeless Adults with SMI

Goal: To provide coordinated services for homeless persons with mental illness.

Strategy: DMH will continue to provide specialized services for homeless individuals with mental illness in targeted areas of the state.

Performance Indicator: The number of persons with serious mental illness served through specialized programs for homeless persons (750)

Description of Collecting and Measuring Changes in Performance Indicator: Adult Services State Plan Survey; PATH Grant Annual Report.

Priority Area #9: Targeted Services to Rural and Homeless Adults with SMI

Goal: To educate providers, consumers and other interested individuals/groups about the needs of homeless individuals, including the needs of homeless persons with mental illness.

Strategy: A DMH staff member will continue to participate on interagency workgroups that

identify and/or address the needs of individuals who are homeless. A DMH staff member continues to participate in the three Continua of Care in Mississippi (Open Doors, Mississippi United to End Homelessness, Partners to End Homelessness), as well as MISSIONLinks, Project Connect, the DMH Housing Task Force and the State Planning Council meetings. A DMH staff member has presented information to these groups on both the PATH Program and the State SOAR Initiative.

Performance Indicator: The number of workgroups addressing homelessness on which DMH staff member(s) participate (up to three)

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of workgroup meetings and/or Division Activity Reports

Priority Area #9: Targeted Services to Rural and Homeless Adults with SMI

Goal: To make available mental health services to individuals in rural areas.

Strategy: Availability of plans by community mental health centers for outreach, including transportation services.

Performance Indicator: The number of CMHCs that have available local plans that address transportation services (15)

Description of Collecting and Measuring Changes in Performance Indicator: Community support services plan reviews.

Priority #10: Management Systems

Priority Area #10: Management Systems

Goal: To develop a uniform, comprehensive, automated information management system for all programs administered and/or funded by the Department of Mental Health.

Strategy: A) Work will continue to coordinate the further development and maintenance of uniform data reporting and further development and maintenance of uniform data standards across service providers. Projected activities may include, but are not limited to:

- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the CMHS MH DIG Quality Improvement project;
- Periodic review and Revision of the DMH Manual of Uniform Data Standards;
- Continued communication with and/or provision of technical support needed by DMH Central Office programmatic staff who are developing performance/outcome measures

(B) Continued communication with service providers to monitor and address technical assistance/training needs. Activities may include, but not be limited to:

- Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs:
- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the MH DIG Quality Improvement project;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Performance Indicator: Progress on tasks specified in the Strategy.

Description of Collecting and Measuring Changes in Performance Indicator:
URS Tables

Priority Area #10: Management Systems

Goal: To maintain a toll-free consumer help line for receiving requests for information, referrals and for investigating and resolving consumer complaints and grievances and to track and report the nature and frequency of these calls.

Strategy: Continued tracking of the nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software.

Performance Indicator: The number of reports generated and distributed to DMH staff and the Office of Consumer Support (OCS) Advisory Council at least three quarterly reports and two annual reports).

Description of Collecting and Measuring Changes in Performance Indicator: Data provided through the software, as calls to the OCS help line logged into the computer system.

Priority Area #10: Management Systems

Goal: To increase funds available for community services for children with serious emotional disturbance and adults with serious mental illness.

Strategy: The Department of Mental Health will seek additional funds in its FY 2013 budget request for community support services for children with serious emotional that disturbances and adults with serious mental illness. Budget requests for the year that begins July 1, 2012 and ends June 30, 2013, were due August 1, 2011. Current plans re to request sufficient funding to maintain the level of operations that will occur during the year that begins July 1, 2011, in addition to sufficient funding to begin expanding community-based services as outlined in the DMH Strategic Plan. A copy of that plan is available on the DMH website

(www.dmh.state.ms.us). This plan has a heavy emphasis on expanding community services, while concurrently reducing residential services. The main issue standing in the way is "bridge funding." That is, to successfully move an inpatient to a community program, one must first create the community program (which means increased expenditures for awhile because both the community program and the institutional program must exist for the transition period), and the individual served must also have an adequate place to live and access to transportation once discharged from residential care. Bridge funding will almost certainly be a part of the budget request.

Performance Indicator: Inclusion of request for increased state funds to support community mental health services for children in the FY 2013 DMH Budget Request.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Budget Request, FY 2012.

***Footnote:** DMH has also advised legislative leaders of an investigation by the Justice Department to determine if Mississippi is violating the civil rights of consumers of mental health services, and has advised them that a supplemental budget request might be made to address findings if those findings are released during the legislative session.

Note to Reader: The DMH is maintaining the following listing of projected expenditures of CMHS Block Grant funds by major service type and provider in its text documents of the State Plan, including a slight increase (to be used for children's services training) in the final FY 2011 award. Although these tables are not required/will not appear in CMHS's online application system document, they are being retained for reference by the Planning Council/other interested stakeholders.

Projected Expenditures of Center for Mental Health Services Block Grant Funds for Children's Community Mental Health Services by Type of Service for FY 2012-2013

Service	**Projected Expenditures**
Intensive Crisis Intervention	$186, 756
Specialized/Multi-Disciplinary Sexual Abuse Intervention	$30, 000
Community Residential	
Therapeutic Group Homes	$225,722
Therapeutic Foster Care	$30,000
Crisis Intervention/Response Models	$447, 040
Respite	$71,831

Multidisciplinary Assessment & Planning Teams (including State-level Case Review Team)	$357,089
Therapeutic Nursing Services	$84,000
Peer Monitoring	$12,000
Training/Education/Staff Development	$106,160
TOTAL	$1,550,418

Projected Allocation of FY 2012-2013CMHS Block Grant Funds
For Children's Services by Region/Provider

Providers	**Projected Allocation**
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley, Executive Director (MAP Team flexible funds)	$15,357
Communicare 152 Highway 7 South Oxford, Mississippi 38655 Sandy Rogers, Ph.D., Executive Director (MAP Team flexible funds)	$17,000
Region III Mental Health Center 2434 S. Eason Blvd. Tupelo, MS 38801 Robert J. Smith, Executive Director (Intensive Crisis Intervention; MAP Team flexible funds)	$48,565
Timber Hills Mental Health Services P. O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Executive Director (Therapeutic Nursing Services, MAP Team flexible funds, and new Comprehensive Crisis Service Array)	$158,620
Delta Community Mental Health Services 1654 East Union St. Greenville, MS 38704 Richard Duggin, Executive Director	$10,000

(MAP Team flexible funds)

Life Help $13,601
P.O. Box 1505
Greenwood, MS 38935
Madolyn Smith, Executive Director
(MAP Team flexible funds)

Community Counseling Services $83, 159
P. O. Box 1188
Starkville, MS 39759
Jackie Edwards, Executive Director
(Crisis Intervention/Emergency
Response, and MAP Team flexible funding)

Region 8 Mental Health Services $106,745
P.O. Box 88
Brandon, MS 39043
Dave Van, Executive Director
(Crisis intervention/emergency response,
MAP Team flexible funding)

Weems Community Mental Health Center $28, 324
P.O. Box 4378
Meridian, MS 39304
Maurice Kahlmus, Executive Director
(MAP Team flexible funding)

Catholic Charities, Inc., Natchez (Region 11) $10,357
200 N. Congress, Suite 100
Jackson, MS 39201
Greg Patin, Executive Director
(MAP Team flexible funding)

Southwest MS Mental Health Complex $15,000
P.O. Box 768
McComb, MS 39649-0768
Steve Ellis, Ph.D., Executive Director
(MAP Team flexible funding, Pike County)

Pine Belt Mental Healthcare Resources $15,000
P.O. Drawer 1030
Hattiesburg, MS 39401
Jerry Mayo, Executive Director
(MAP Team flexible funding)

Gulf Coast Mental Health Center

1600 Broad Avenue $35,528
Gulfport, MS 39501-3603
Jeffrey L. Bennett, Executive Director
(Intensive Crisis Intervention, MAP Team
flexible funding)

Singing River Services $15,357
101-A Industrial Park Road
Lucedale, MS 39452
Sherman Blackwell, II, Executive Director
(MAP Team flexible funding)

Warren-Yazoo Mental Health Services $70,357
P. O. Box 820691
Vicksburg, MS 39182
Steve Roark, Executive Director
(Intensive Case Management and MAP Team flexible funding)

Catholic Charities, Inc. $365,398
200 N. Congress St., Suite 100
Jackson, MS 39201
Greg Patin**,** Executive Director
(Family Crisis Intervention, TFC, and Comprehensive
Emergency/Crisis Response & Aftercare Model, TFC,
TF-CBT training and MAP Team flexible funding)

Gulf Coast Women's Center $21,000
P. O. Box 333
Biloxi, MS 39533
Sandra Morrison, Director
(Intensive Crisis Intervention)

Mississippi Children's Home Society and CARES Center $125,722
P.O. Box 1078
Jackson, MS 39215-1078
Christopher Cherney, CEO
(Therapeutic Group Home)

MS Families As Allies for Children's Mental Health, Inc.
5166 Keele St., Bldg. A $155,740
Jackson, MS 39206
Tessie Schweitzer, Interim Executive Director
(Crisis Intervention/Respite, flexible funding for services
for youth by the State-level Interagency Case Review Team,
other System of Care (SOC) development activities (ex.: more
flexible funds, as needed; SOC training; ICCCY planning/activities)

Southern Christian Services for Children and Youth 1900 North West St., Suite B Jackson, MS 39202 Sue Cherney, Executive Director (Mental Health Services for Transitional TGHs and Training)	$165,739
Vicksburg Family Development Service P. O. Box 64 Vicksburg, MS 39180 Kay Lee, Director (Sexual Abuse Intervention)	$30,000
Department of Mental Health 1101 Robert E. Lee Building 239 North Lamar St. Jackson, MS 39201 Edwin C. LeGrand III, Executive Director (Funds to support peer monitoring, and and training, which may be granted to local entities for implementation)	$45,649
TOTAL	$1,550,418

Note: A total of $187,781 (5% of the total amended award to be spent on services in FY 2012-FY 2013) will be used by the Mississippi Department of Mental Health for administration. It is projected that $77,521 will be spent for administrative expenses related to children's community mental health services.

Projected FY 2012-2013 CMHS Block Grant Projected Expenditures by Type of Service for Adults with Serious Mental Illness

Service	**Projected Est. Expend.**
Individual Therapy	$353,761
Medication Evaluation/Monitoring	$79,523
Family Therapy	$3,804
Group Therapy	$26,283
Psychosocial Rehabilitation/Employment Enhancement	$616.799.48
Nursing Services	$43,340
IM/SC Administration of Psychotropic Medication	$1,558

Case Management /ICM	$ 741,829
Emergency	$34,264
Community Residential	$34,822
Consumer and Family Education/Support	$127,006
Peer Review/Technical Assistance	$32,376.52
Drop-in Center	$69,660
Adult Making A Plan (AMAP) Teams	$29,315
Transportation pilot program	$10,870
TOTAL	$2,205,211

Projected Allocation of FY 2012-2013 CMHS Block Grant Funds for Adult Services by Region/Provider

Provider	**Projected Allocation**
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley, Executive Director	$99,167.14
Communicare 152 Highway 7 South Oxford, MS 38655 Sandy Rogers, Ph.D., Executive Director	$126,368.13
Region III Mental Health Center 2434 S. Eason Boulevard Tupelo, MS 38801 Robert J. Smith, Executive Director	$114,425.14
Timber Hills Mental Health Services P.O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Executive Director	$131,843.14
Delta Community Mental Health Services P.O. Box 5365	$121,818.00

Greenville, MS 38704-5365
Richard Duggin
Executive Director

Life Help $146,453.00
P.O. Box 1505
Greenwood, MS 38930
Madolyn Smith, Executive Director

Community Counseling Services $130,475.00
P.O. Box 1188
Starkville, MS 39759
Jackie Edwards, Executive Director

Region 8 Mental Health Services $134,349.00
P.O. Box 88
Brandon, MS 39043
Dave Van, Executive Director

Hinds Behavioral Health Services $140,758.13
P.O. Box 7777
Jackson, MS 39284
Margaret L. Harris, Director

Weems Community Mental Health Center $138,304.13
P.O. Box 4378
Meridian, MS 39304
Maurice Kahlmus, Executive Director

Southwest Mississippi Mental Health Complex $134,603.13
P.O. Box 768
McComb, MS 39649
Steve Ellis, Ph.D. Executive Director

Pine Belt Mental Healthcare Resources $150,979.13
P.O. Box 1030
Hattiesburg, MS 39401
Jerry Mayo, Executive Director

Gulf Coast Mental Health Center $136,553.13
1600 Broad Avenue
Gulfport, MS 39501-3603
Jeffrey L. Bennett, Executive Director

Singing River Services $101,484.14
3407 Shamrock Court
Gautier, MS 39553
Sherman Blackwell III, Executive Director

Warren-Yazoo Mental Health Services P.O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director	$92,885.14
NAMI-MS 411 Briarwood Drive - Suite 401 Jackson, MS 39206 Tonya Tate, Executive Director	$67,802.00
Mental Health Association of Mississippi P.O. Box 7329 4803 Harrison Circle Gulfport, MS 39507 Kay Denault, Executive Director	$66,691.00
MS Department of Mental Health 1101 Robert E. Lee Building 239 North Lamar Street Jackson, MS 39201 Edwin C. LeGrand III, Executive Director	
Funds to support consumer and family education/training opportunities at annual state conference, as well as other local, state or national education/training opportunities	$127,006.00
Funds to support enhancement of employment opportunities	Amt. included in awards for Region 5
Funds to support peer monitoring (Funds listed under DMH may be granted to local entities for implementation)	$32,376.52
Funds to support pilot transportation project	$10,870
Total	$2,205,211

Note: A total of $187,781 (5% of the total amended award to be spent on services in FY 2012-FY 2013) will be used by the Mississippi Department of Mental Health for administration. It is projected that $110,260 will be spent for administrative expenses related to adult community mental health services.

III: Use of Block Grant Dollars for Block Grant Activities

Services Purchased Using Reimbursement Strategy

Table 4 Plan Year: 2012-2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract reimbursement	**Child/Youth:** Intensive Crisis Intervention, Mobile Crisis Response, Prevention/Early Intervention, Family/Education Support, Therapeutic Group Homes, Therapeutic Foster Care, Respite, Therapeutic Nursing Services, Evidence-based Practices, Training/Workforce Development, Non-traditional Services (mentoring, recreational services, transportation, and housing assistance **Adult:** Purchase of service grants offer individual, family and group therapy, medication evaluation and monitoring, psychosocial rehabilitation, nursing services, case management, emergency services, intensive case management, AMAP Teams, and transportation **Consumer and Family Affairs:** Consumer and family education/support, peer review/technical assistance, Leadership Academy, Drop-In Center, consumer and family training/conference opportunities
Risk based reimbursement	
Innovative Financing Strategy	
Other reimbursement Strategy (please describe)	

Projected Expenditures for Treatment and Recovery Supports

Table 5 Plan Year: 2012-2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed				
		<10%	10-25%	26-50%	51-75%	Over 75%
Healthcare Home/Physical Health	Generalized and specialized outpatient services Acute Primary Care General Health Screens***** Comprehensive Care Management Individual and Family Support***** Referral to Community Services Nursing Services*****	**$43,430 (Adult)**	**$197,579 (CYS)**			
Engagement Services	Assessment***** Specialized Evaluation***** Services planning Consumer/Family Education ***** Outreach* AMAP *****	**$67,802 (DCFA)** **$29,315 (Adult)** **$149,293 (CYS)**				
Outpatient Services	Individual Evidence-based therapies Group Therapy Family Therapy Multi-family Therapy Consultation to Caregivers	**$123,929 (CYS)**			**$1,069,734 (Adult)**	
Medication	Medication Management*****	**$81, 081**				

Services	Pharmacotherapy Laboratory Services	**(Adult)** **$35,709 (CYS)**				
Community Support (Rehabilitative)	Parent/Caregiver Support***** Skill Building ***(Drop-In)** Case Management***** Behavior Management Supported Employment Permanent supported housing Recovery housing *** (Drop-In)** Therapeutic mentoring Traditional healing services	**$69, 689 (DCFA)**	**$259,568 (CYS)**	**$741, 829 (Adult)**		
Recovery Supports	Peer Support***** Recovery Support Coaching Recovery Support Center Services Supports for Self-Directed Care*	**$99,409 (DCFA)** **$35,709 (CYS)**				
Other Supports (Habilitative)	Personal Care Homemaker Respite***** Supported Education Transportation***** Assisted Living Services***** Recreational Services***** Interactive Communication Technology Devices Trained Behavioral Health Interpreters*****	**$10,870 (Adult)**	**$270,405 (CYS)**			
Intensive Support Services	Substance Abuse Intensive Outpatient Services Partial Hospitalization Assertive community treatment Intensive home-based treatment***** Multi-systemic therapy Intensive case management*****			**$404,475 (CYS)**		
Out-of Home Residential Services	Crisis residential/stabilization Clinically Managed 24-Hour Care Clinically Managed Medium Intensity Care Adult Mental Health Residential Adult Substance Abuse Residential Children's Mental Health Residential***** Youth Substance Abuse Residential Therapeutic Foster Care*****		**$255,722 (CYS)**			
Acute Intensive Services	Mobile Crisis Services***** Medically Monitored Intensive Inpatient Peer based crisis services Urgent care services 23 hour crisis stabilization services 24/7 crisis hotline services		**$182,010 (CYS)**			
Prevention (Including Promotion)	Screening, Brief Intervention , and Referral to Treatment***** Brief Motivational Interviewing Screening and Brief Intervention for Tobacco Cessation Parent Training*****		**$172,835 (CYS)**			

	Facilitated Referrals***** Relapse Prevention/ Wellness Recovery Support Warm line					
System Improvement Activities	Peer Review Monitoring***** Workforce Development Training*****	**$32,376 (DCFA)** **$45,649 (CYS)**				
Other						

*CYS – Children and Youth Services
*Adult – Adult Services
*DCFA – Division of Consumer and Family Affairs

Table 6 Primary Prevention Planned Expenditures Checklist: According to page 29 of the FY 2012-2013 Block Grant Application Guidance, the Primary Prevention Planned Expenditures Checklist is for projecting expenditures for substance abuse prevention activities. Table 6 will be submitted with Mississippi's SABG.

Projected State Agency Expenditure Report
Table 7
Plan Year: 2012-2013
State Identifier: Mississippi

Projected State Agency Expenditures Report						
	Sources of Funding					
Activity	**A. Block Grant**	**B. Medicaid (Federal, State, and local)**	**C. Other Federal Funds**	**D. State Funds**	**E. Local Funds**	**F. Other**
1. Substance Abuse Prevention and Treatment						
2. Primary Prevention						
3. Tuberculosis Services						
4. HIV Early Intervention Services						
5. State Hospital						
6. Other 24 Hour Care						
7. Ambulatory / Community Non-24 Hour Care	**$1,550,418 (CYS)** **$269,276 (DCFA)** **$2,205,211 (Adult)**		**$2,646,432 (CYS)**	**$2,633,238 (CYS)** **$13,957 (DCFA)** **$17,690,137 (Adult)**		
8. Administration						
9. Subtotal (Rows 1,2,3,4, and 8)						
10. Subtotal (Rows 5, 6, 7, and 8)						
11. Total						

*CYS – Children and Youth Services
*Adult – Adult Services
*DCFA – Division of Consumer and Family Affairs

Table 8: Resource Development Planned Expenditures Checklist: According to page 29 of the FY 2012-2013 Block Grant Guidance, Table 8 requests information regarding the SABG Projected Resource Development Expenditures. This information will be submitted with Mississippi's SABG Application.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

The *Department of Mental Health Operational Standards* require that providers conduct an Initial Intake Assessment for all individuals in the caseload with a serious mental illness. The assessment is conducted with every individual who has a serious mental illness within 14 days of referral for outpatient services and within seven days of admission for all residential treatment services. It is determined if the assessments will be completed during the annual site/certification visits. Staff from the DMH will review timelines on site visits to ensure assessments were conducted.

The DMH Division of Community Services and the community mental health regions have adopted the philosophy to provide more person-directed, recovery-oriented services to people in the system of care. The Division of Community Services continues to review existing service standards for potential revisions which support sustaining PCP initiatives in the future. The Division of Community Services, NAMI-MS, the Mississippi Leadership Academy, and the Mental Health Association are also mindful of the principle of person-directed services in the training they provide to individuals receiving services and their families.

In 2009, DMH began a ten-year strategic planning effort to guide and direct the department in transformation to a community-based system that promotes recovery and resiliency. One of the main themes throughout the plan calls for the agency and services to be more person-centered and person-directed. DMH also began the revision/updating of the DMH standards for operation of community mental health programs in which DMH has incorporated the person centered/directed philosophy.

E. Data and Information Technology

DMH has a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and will house timely and accurate information that is detailed to the client level from all DMH certified and funded providers. As a result, the DMH now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. The CDR contains common data elements that the DMH requires all programs to collect for agency-wide demographic and statistical reporting, as well as data elements required for completing the Uniform Reporting Standards (URS) tables. The client data is collect in episodes. An Episode is defined as the time from date of admission to the organization to the date of discharge from that organization. Although the CDR does collect information on the clients "service experience" which shows when services were received by a client and what payor pays for that service, it does not currently include a field for determining

"funded through the block grant". We do collect Medicaid number if available, and whether or not the client is eligible to receive Medicaid; but we do not currently link this data with Medicaid data.

The Department of Mental Health will continue ongoing efforts to implement a more standardized system of computerized data collection, including data needed for reporting on the National Outcome Measures (NOMS) and data needed for reporting in the Uniform Reporting System tables requested by the federal Center for Mental Health Services (CMHS). The DMH has used the DIG funds to support design, refinement and implementation of reporting systems that will facilitate community service providers' and state psychiatric hospitals' submission of data. The DMH has continued to use DIG funds to support collection and reporting of consumer satisfaction survey information for adults and families of youth served by the public community mental health system. Consumer satisfaction survey information is also being collected
In 2010, DMH received funding of The Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2011 – FY 2013) which will enable the Mississippi Department of Mental Health to continue work needed to build its infrastructure and refine its capacity to report quality data for the National Outcome Measures (NOMs) reported in the Mississippi State Plan for Community Mental Health Services and the related annual Implementation Report. The project will focus on developing infrastructure for reporting of client-level data for five targeted NOMs and for increasing and improving reporting of other NOMs and Uniform Reporting System (URS) data defined for the Community Mental Health Services Block Grant program. Goals of the proposed project are: (1) Refine reporting of client-level data for targeted NOMs and improving reporting of other NOMs/URS tables; (2) Ensure standard definition use; (3) Refine data infrastructure for capturing, reporting, and storing URS data needed for NOMs/URS reporting, including targeted client-level NOMs; (4) Develop/implement specific strategies for improving data integrity; (5) Work with other stakeholders on refinements and/or additions to the NOMs/URS system tables; and, (6) Improve understanding and use of satisfaction survey data.

The State, Governor's office per law, HB941, created the Health Information Network Board (MHIN), which includes a Mississippi Department of Mental Health employee. The Board is currently refining its By-Laws. Mississippi's HIE Strategic and Operational Plan has been created, submitted and approved by the Office of the National Coordinator (ONC). The Board is working under the ARRA funding and determining a sustainable financial plan and model is a top priority of the Board. The Information Technology Services agency is the lead agency. Part of the executive director's job duties will be developing policies, standards, etc. This effort was also completed with the MS Coastal Health Information Exchange (MSCHIE) project involving Gulfport Memorial, and Singing River hospitals. The MHIN board continued this process with the state HIE Strategic and Operational Plan. State psychiatric hospitals are participating in the state's Medicaid Health Information Exchange (HIE) Program. DMH is partnering with the Mississippi Department of Information Technology Services and MSHIN to establish a system for statewide HIE.

F: Quality Improvement Reporting

The Mississippi Department of Mental Health does not currently have a system-wide Continuous Quality Improvement/Total Quality Management Plan. However, the Department has implemented various processes to track and measure the effectiveness of services and supports,

programmatic improvements, and stakeholder input. *The DMH Operational Standards for Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse Community Service Providers* requires certified service providers to establish at least one outcome measure and describe the data collection/evaluation system for each service for which the provider is certified. The outcome measures are included in the provider's Annual Operation Plan and must be available for review by the Department of Mental Health. Mississippi began implementation of the Board of Mental Health and Department of Mental Health Strategic plan two years ago. The purpose of the Strategic Plan is to identify strategies and activities that will generate significant, measurable gains in transforming DMH's service system. The five goals of the Strategic Plan include objectives, action plans, performance measures, timelines, and responsible parties focused on producing observable, measurable outcomes. Goal Teams are comprised of individuals in recovery or receiving services and their family members, community mental health center staff, staff employed by nonprofit service providers, and individuals from advocacy organizations. Quarterly reports of the Strategic Plan are generated to track achievement of the objectives and determine the need to modify or create new objectives to meet the needs of the changing service system.

In 2011, the peer review process implemented in previous years was replaced with the Council on Quality Leadership's (CQL) Personal Outcome Measures 2005©, which are now the foundation for the peer review process. The Council on Quality Leadership is an international not-for-profit organization dedicated to being the leader for excellence in the definition, measurement, and evaluation of personal and community quality of life for people with disabilities and people with mental illness. Personal Outcome Measures is a tool for evaluating personal quality of life and the degree to which organizations individualize supports services to facilitate better outcomes. People define outcomes for themselves. Personal outcomes are important because they put **"**listening to" and "learning from" the person at the center of organizational life. There are 21 personal outcome measures for adults; 22 for children and young adults; and 20 for families and children under 5 years of age. As of March 2011, 37 individuals receiving services, family members and mental health professionals have been trained to conduct personal outcome interviews. As of March 2011, personal outcome interviews have been conducted at Life Help and Hinds Behavioral Health with 46 adults and/or children, young adults or families with children under 5 years of age.

The DMH Operational Standards for Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse Community Service Providers also requires certified providers to have a written process for meaningful individual and family involvement in service system planning, decision making, implementation, and evaluation. In addition, individuals in recovery, individuals receiving services, family members, state agency representatives, and service provider representatives provide feedback on the quality of the services delivered through their participation on advisory councils including the Mississippi State Mental Health Planning and Advisory Council, the Bureau of Intellectual and Developmental Disabilities State Plan Advisory Council, the Office of Consumer Supports Advisory Council, the Mississippi Alzheimer's Disease and Other Dementia Planning Council, and the Mississippi Alcohol and Drug Abuse Advisory Council.

The MS Department of Mental Health continues efforts to address provision of the comprehensive Mental Health Reform Act, passed by the State Legislature in 1997. Consistent with the call for increased access, quality and accountability of services in the Mental Health

Reform Act, and, in the agency's Strategic Plan, the Mississippi Department of Mental Health continues to improve its system of program evaluation and planning. In 2011, the MS State Legislature passed Senate Bill 2836. This bill named after the sister of MS author, Tennessee Williams, reinforced the goal of the state mental health delivery system which is to provide services and support to citizens in the community where they live. It also requires that certain core services are provided in each county. CMHCs are required to submit an annual operational plan each year to the DMH. These efforts also address improving performance and outcome measurement and reporting at the local and state levels, including increasing capacity to report on National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA). In accordance with new SAMHSA/CMHS guidance for application for CMHS Block Grant funds, specific goals, data from previous years and targets for National Outcome Measures (NOMs) will be reported in the annual Implementation Report (rather than in the State Plan). Results on targeted NOMs will be reported as instructed. It is projected that the MHSIP Consumer Satisfaction Survey and the Family/Caregiver Satisfaction Survey (Youth Services Survey-Families, YSS-F) will continue to be administered statewide to a representative sample of consumers and family members/caregivers (for youth) who received services from DMH certified/funded community mental health service providers. From results of these surveys, NOMs for child and adult services on client perception of care (outcomes domain), functioning, social connectedness, criminal justice (adults) or juvenile justice (youth) involvement and school attendance (youth) will continue to be reported. Other NOMs projected to be included in the FY 2012-2013 Reports include: access to care, state psychiatric inpatient readmissions (30 days and 90 days), percentage of individuals who are homeless/in shelters, percentage of individuals who are employed and data on SAMHSA-specified evidence-based practices (e.g., therapeutic foster care, illness management/recovery). Consistent with the Quality Improvement Data Infrastructure Grant (DIG) project goals, activities to increase reporting on evidence-based practices and to transition to client-based reporting for outcome measures as specified by SAMHSA/CMHS will also continue.

In August 2011, DMH created the Bureau of Quality Management, Operations and Standards. Responsibilities of this Bureau are noted in Part II. Step 1: Organizational Structure of the Mississippi Department of Mental Health, DMH Central Office.
The Office of Consumer Supports (OCS) was established by the Department of Mental Health in response to a provision in the Mental Health Reform Act. The major responsibilities of this office include establishing and maintaining a 24 hour toll-free help line for responding to needs for information by consumers and their family members and other callers to the help line. This office is also responsible for responding and attempting to resolve consumer complaints about services operated and/or certified by the Department of Mental Health. Policies and procedures have been developed for resolving consumer complaints, both formally and informally. This office also maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. Information is accessible to all callers through staff via a toll-free telephone number. The number is accessible 24 hours a day, seven days a week. OCS is also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals according to established policies and procedures. Data from these calls are included in the quarterly reports. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific

referrals to individuals that identify themselves as a veteran. The *DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers* address services provided by OCS, including: (1) accessing the help line for information, referrals and complaints; (2) reporting serious incidents to DMH; and, (3) the availability of local grievance procedures, as well as procedures for grievances through OCS.

OCS staff participates in certification visits to each program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. This Office also continues to process and attempt to resolve consumer complaints through formal and informal procedures and track calls to develop reports for DMH management staff. Reports about the nature and frequency of calls to the help line (deleting all confidential information) are distributed quarterly to the DMH Executive Director, Bureau Directors and the OCS Advisory Council. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS has developed training modules on serious incident reporting, handling crisis and suicide calls, and any applicable operational standards monitored by OCS. These modules are available as requested by any DMH-certified program.

OCS continue**s** to meet biannually with an advisory council, which includes family, consumer and service provider representatives of all major service areas administered by DMH.

G. Consultation with Tribes

DMH Division of Children and Youth staff provided FASD-specific education, diagnosis and training to staff at Choctaw Behavioral Health Services. Training was provided to case managers, social workers, and other staff within the Choctaw Tribal Agency in August 2011. The primary goal of this effort was to provide FASD prevention and intervention services to families and children within the Choctaw Tribal Agency. Plans are also being developed to adapt or modify the FASD curriculum to be more appropriate for the Choctaw culture and educate Choctaw Behavioral Health staff to become facilitators to continue training newly hired staff and maintain their own training and updates long-term.

The provision of FASD training to the Mississippi Band of Choctaws is an objective that has been included in the 2011-2013 FASD State Plan. Mississippi's FASD State Plan is developed and implemented by the Mississippi Advisory Council on FASD (MS AC-FASD) which is made up of representatives from at least fifteen state and local agencies and programs that have a direct interest and involvement in children and families who are affected by FASD. The MS AC-FASD also includes a representative from the Band of Choctaws.

In March 2011, the Mississippi Trauma Recovery for Youth (TRY) Project, led by Catholic Charities, Inc., began its second Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Learning Collaborative with 24 participants from two CMHCs and the MS Band of Choctaw Indians Behavioral Health. The conceptual framework of the project involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practice, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. The project also involves tracking of provision of services and treatment outcomes over a period of time. The Learning Collaborative will conclude in October 2011.

An individual from the Choctaw Tribe, working in the area of youth and substance abuse, participated in the development of the DMH Cultural Competency Plan, as well as the National Minority Mental Health Awareness Event sponsored by the DMH (July 23, 2010). On March 25-26, 2010, a DMH staff member attended a conference on the reservation entitled, "Connecting Healthcare Providers and the Community to Improve Health Disparities Among Native Americans," which was sponsored by the Delta Region, Southeast, and North Carolina AIDS Education and Training Centers. On January 7, 2010, this DMH staff member also participated on a Cultural and Linguistic Community of Practice conference call called "Transgenerational Trauma and Its Effects on Families and Communities" with speaker Dr. Eduardo Duran regarding Native Americans and their land issues. A woman who was raised on a reservation came to Mississippi from Lambda Legal to conduct a workshop for DMH administrators and service providers on Lesbian/Gay/Bisexual/Transexual Cultural Competency through the Technical Assistance Partnership.

The Bureau of Alcohol and Drug Abuse (BADA) has a statewide Alcohol and Drug Abuse Advisory Council which meets quarterly. A member of the Council is the Director of Choctaw Behavioral Health, Choctaw Tribal Agency located in Philadelphia, MS. The Choctaw Tribal Agency works closely with BADA and administers two federal grants through the BADA office, prevention and workforce development. The SureTool, an internet substance abuse prevention database is utilized to gather specific information regarding Tribes. Additionally, the Department of Mental Health is in communication with the administration of the Mississippi Band of Choctaw Indians regarding adding a representative to the Mississippi State Mental Health Planning and Advisory Council; it is anticipated that confirmation of a representative's appointment will be accomplished in the next several weeks (i.e., before or soon after submission of the CMHS Block Grant application).

H. Service Management Strategies

The Division of Audit and Grants Management audits grants awarded by the Divisions within the Bureau of Community Services. Subgrant audits are after the fact and insure that services and expenses that were reimbursed to the facilities were actually paid. These audits are conducted annually, or at least biannually, depending on the risk assessment of the program. The Division staff sign off on monthly reimbursement requests, which list cumulative totals of amounts spent to date. The balance for each grant is posted under "Grant Balances" on a common drive accessible to Division staff that automatically updates when a request is approved from our system. Division staff use this information to determine if unused or excessive funds need to be reallocated to other grants to insure utilization of funds as the grant year is coming to a close.

Regional community mental health centers are required in local community services plans (submitted to the Bureau of Community Services in proposals for CMHS Block Grant funds) to describe how these services and other community support services for adults with serious mental illness will be provided at the local level, addressing the following components: outpatient services; family and consumer support; access to inpatient services; availability of alternative living arrangement services; protection and advocacy; programs for psychosocial and vocational rehabilitation; crisis response system; case management; outreach; and, access to medical/dental services and to other support services, such as transportation and social activities.

I. State Dashboards

As requested by SAMHSA, Table 10 identifies state-specific performance indicators for the creation of a State Dashboard.

Table 10 Plan Year 2012-2013

Priority Area	Performance Indicator
Interagency Collaboration for Children and Youth with SED	52 MAP teams will receive or have access to flexible funding through DMH
Integrated Services for Children and Youth with SED	Four (4) MTOP local project sites will develop and provide specialized services/resources for youth and young adults, 16-21 years
Comprehensive Community-Based Mental Health Systems for Adults with SMI	25 employed individuals with serious and persistent mental illness

Why were these state specific measures selected?

The Priority Areas identified coincide with objectives and action plans included in the Department of Mental Health's Strategic Plan. It is the intent of DMH to increase the number of supported employment options across the state. DMH has been working on developing housing and transportation options for individuals with serious and persistent mental illness. DMH feels that with the additional focus on supported employment where individuals can have meaningful employment, safe and affordable housing, and transportation will allow them to achieve recovery and community inclusion.

J. Suicide Prevention

The DMH, working in collaboration with the Department of Defense and local authorities, has specific initiatives to promote mental health awareness by providing information to active duty military, veterans, National Guard members, the Reserve and family members of the military on accessing needed mental health services. The SMHA serves on the Joint Behavioral Health Task Force and developed the military campaign, *Operation Resiliency*, which focuses on mental health awareness for returning veterans and their family members. *Operation Resiliency* will reach all National Guard units across the state through brochures, posters, and resource guides and 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. Resource guides have been distributed to 500 men and women in the National Guard. In addition, the Bureau of Alcohol and Drug Abuse works closely with the Mississippi National Guard in prevention efforts with the MS public and private schools. A Colonel from the Guard serves on the State Alcohol and Drug Abuse Advisory Council.

The Youth Suicide Prevention Advisory Council was created in 2006 upon receipt of a grant from SAMHSA targeting the Gulf Coast Counties after Hurricane Katrina. The Council supported and approved a statewide plan for addressing suicide prevention in 2007. DMH submitted an application for a statewide Suicide Prevention Grant in 2009, which was not awarded. However, DMH submitted another application in 2011. The Council will begin revising and updating the Youth Suicide Prevention Plan in 2011. Since 2007, the Council assisted with the development of DMH's Youth Suicide Prevention Campaign, "Shatter the Silence;" coordinated the first annual Youth Suicide Prevention Conference in 2008; coordinated a Youth Suicide Prevention Pre-Conference in 2008; supported the passage of Senate Bill 2770 in 2009 which calls for the Mississippi Department of Education to require local school districts to conduct in-service training on suicide prevention for all licensed teachers and principals. DMH, Division of Children and Youth Services continues to have two certified trainers in Applied Suicide Intervention Skills Training (A.S.I.S.T.) that train providers across the state including mental health professionals, social workers, youth court counselors, youth detention center staff and family partners. Finally, DMH's Office of Consumer Supports contracts with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in Mississippi. The federally funded NSPL routes callers from Mississippi to the DMH Office of Consumer Supports for crisis intervention, suicide prevention, and resource referrals. (See Appendix A: Mississippi Youth Suicide Prevention Plan.) DMH staff is reviewing a draft suicide prevention plan for adults, after which it will be revised as needed.

K. Technical Assistance Needs

Children's Services:

Qualified staff continue to be needed on the state and local levels to implement Evidence-based Practices and children/youth functional assessments that would provide meaningful data on the program/client outcomes level. Currently, DMH is utilizing resources from the two System of Care Initiatives and the two National Child Stress Traumatic Network sites in the state to train mental health providers in Trauma –focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Combined Parent Child Cognitive Behavioral Therapy (CBC-CBT) and Wraparound based on the University of Maryland's, Innovations Institute Model. The Learning Collaborative Model is being utilized for training on these EBPs which requires three, two day learning sessions and monthly phone calls. The Medicaid State Plan currently does not have an enhanced reimbursement rate for EBPs so incentives for providers to participate in the Learning Collaboratives are being explored. The DMH Operational Standards now require children/youth mental health providers to conduct a functional assessment within 30 days of admission and six months thereafter to measure client's progress. Currently, there is not a common assessment used, but several are being explored for statewide utilization. DMH, Division of Children and Youth Services plans to utilize resources from the two SOC sites to purchase a web-based functional assessment tool for use by mental health professionals to enable them to measure client's progress more accurately than the checklists/tools being utilized currently. Finally, there continues to be a need for state level staff to collect data and outcomes from DMH certified providers for continuous quality improvement activities to include in reports to SAMHSA and to the State Legislators.

Adult Services:

DMH has adhered to the Psychosocial Rehabilitation/Clubhouse Model which subscribes to the Transitional Employment Model. Although this has been an effective tool in job preparedness, it has fallen short due to lack of supported job opportunities. DMH started the Division of Family and Consumer Affairs and have trained Peer Recovery Specialists (based on the Georgia Peer Specialist Model), and have employed Peers to work on both of the State PACT Teams. DMH has petitioned the Division of Medicaid for a state plan amendment to cover Peer Specialists Services as a reimbursable service but to date this has not been achieved. DMH is exploring assistance options to enhance supported employment opportunities to individuals with serious and persistent mental illness.

L. Involvement of Individuals and Families

The DMH continues to work on the development of Certified Peer Specialist services and provides training and technical assistance to consumers and consumer groups to develop skills to aid other mental health consumers in their recovery. Drawing from their own insight into, and experience, with mental illness, CPSs through their similar experiences with mental illnesses give others encouragement, hope, assistance, and understanding that aids in recovery. The program prepares CPSs to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve and is an opportunity for consumers and family members to see that recovery is possible. Since FY 2007, DMH has employed consumers to work part-time in the state office to assist with the peer review process and consumer educational events, as well as to facilitate planning and development of a peer specialist program and employment opportunities. In FY 2008, the DMH established the Division of Family and Consumer Affairs (DCFA) in the Bureau of Community Services, which assumed these responsibilities, as well as oversight of family education programs and drop-in center services. Operational objectives of the division include:

- To ensure that individuals and families are the driving force for improvements in the publicly funded mental health system;
- To help individuals and their families participate in decision-making at all levels of the public mental health system; and,
- To promote the empowerment of individuals and families with mental health needs through education, support and access to mental health services.

Since 2006, the DMH has received technical assistance and training on establishing peer specialist services in the state. A Peer **S**pecialist training session in the fall of 2006 involved individuals receiving services, family members, and service providers in training regarding the peer specialist program and the recovery model. In FY 2008, one of the consumers employed by the DMH in the Division of Consumer and Family Affairs completed the one-week Certified Peer Specialist Training in Kansas. In March, 2008, staff from the Division of Consumer and Family Affairs and NAMI-MS visited the Georgia Peer Support program and received technical assistance on program development from certified peer specialists, Medicaid representatives, and Georgia Department of Mental Health staff. In May 2009, the first group of 16 interested consumers received training in the provision of peer specialist services, based on the Georgia model, and a workshop for providers interested in peer specialist services was provided as part of the 2009 Mental Health Community Conference and in FY 2010, two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. Certified

Peer Specialists have been working to establish bylaws, goals and a mission statement for the Mississippi Peer Leadership Network, a newly formed consumer coalition.
The DMH has three Consumer Coalitions covering all 15 mental health regions. The mission is to improve the lives of consumers of mental health services by providing educational training opportunities and ensure that consumers have a major voice in the development and implementation of mental health care at the State level and empowering people to recover and lead a full life in the community. The Clubhouse Coalition is made up of clubhouse members and staff who attend the clubhouse programs in the 15 mental health regions. Their mission is to support the enhancement and development of psychosocial rehabilitation programs (Clubhouses) in the State.

The State sponsors quarterly meetings for individuals in recovery and family members. The Mental Health Planning and Advisory Council is made up of a balanced number (not less than 50%) of both service providers and non-service providers, including individuals who have or are receiving mental health services and family members. Primary responsibilities include planning and developing comprehensive mental health treatment, support, and rehabilitation services for all individuals. They are also responsible for monitoring, reviewing, evaluating and advising the allocation and adequacy of mental health services within the State. Individuals in recovery and family members also participate on the Mental Health Planning Council committees, such as the Consumer Rights Committee and Children's Services Task Force. These committees examine and consider information on current services and the service delivery processes. Their work to evaluate and learn about issues and needs regarding the mental health system typically leads to recommendations for improvements to the system, including new objectives in the State plan.
The Consumer Rights Committee focuses its efforts on identifying concerns regarding the rights of individuals receiving services and makes recommendations to the Planning and Advisory Council about possible solutions to address those concerns. Although some specific situations involving the rights of individuals may be discussed and even referred to other entities for possible resolution, the main purpose of this committee is to make recommendations to affect changes in the larger system. Minimum standards require community service providers to have an individual/family advisory committee to advise the governing authority of the local provider entity on matters related to individual/family satisfaction, annual operational plans, performance outcomes, program planning and evaluation, quality assurance/improvement, type and amount of services needed and other issues the advisory committee chooses to address. The committees must include family members and individuals served by the provider, as well as other interested individuals, with representation commensurate with the major services provided by the organization (e.g., mental health services, substance abuse services, visits. Compliance with this requirement continues to be monitored by DMH staff on certification/site visits.
Finally, individuals in recovery and family members participate in the on-site peer review visits to local child and adult mental health programs as part of the DMH's peer review and monitoring process.

The Division of Consumer and Family Affairs, which is staffed largely by people who have utilized mental health services, provides training to both service providers and individuals receiving services and reviews, evaluates, and enhance opportunities for consumers and family members to participate fully in all aspects of mental health services. The Division Consumer and Family Affairs Peer Support training increases the active role individuals take in their recovery and dissemination of evidence-based practices, e.g., continued availability of training on person-

centered planning, development of an education campaign that focuses on recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change.

The Multicultural Task Force addresses issues relevant to providing appropriate, culturally sensitive mental health services to minority populations in MS. The task force also provides statewide training using the National Coalition Building Institute's Prejudice Reduction curricula.

The DMH's Office of Consumer Supports is responsible for documentation, investigation and resolution of all complaints/ grievances regarding state and community mental health/mental retardation facilities that are received from individuals receiving services, family members and the general public through the toll-free Helpline.

The *Consumer/ Family Interest Form* was designed to support and strengthen consumer and family member representation on DMH committees, workgroups and task forces. Family members and/or consumers of mental health services who are interested in participating on DMH committees, workgroups, and task forces complete the form and a copy is maintained at DMH. Individuals are assigned to workshops groups, task forces, committees, etc. based on personal interest and/or experience on an as needed basis.

The Division of Consumer and Family Affairs financially supports non-profit organizations that provide peer-directed mental health recovery services to consumers. Through training, technical assistance, and monthly reporting, DMH assists these organizations in their efforts to provide quality peer support services, run by and for consumers of mental health services. NAMI-MS provides family education (Family-to-Family) programs and support groups to help family members learn essential skills and information related to caring for a family member diagnosed with a mental illness and consumer education programs (Peer to Peer) to consumers diagnosed with a mental illness. Drop-in Centers provide a wide range of services to consumers of mental health services which include social and recreational programs, information and referral, consumer education and advocacy, with a strong emphasis on empowering and involving consumers of mental health services in providing support to others.

Mississippi Mental Health Recovery Social Network is a social network for the mental health community founded by certified peer specialists, consumers of mental health services and representatives of the Department of Mental Health. The primary purpose of Mississippi Recovery Network is to connect individuals affected by mental illness. Participants can use the Network to connect with others who share similar stories, experiences, and goals and other topics of interest; find resources and get support on mental health issues; engage in positive discussion around mental health with forums, blogs, and community groups; search for and collaborate in producing information; and keep track of upcoming events like training courses, exhibitions, group meetings, seminars, and conferences.

Our State is fortunate to have the Mississippi Leadership Academy, which has proven successful for adults with mental health and/or co-occurring concerns because it emphasizes the importance of peer-support, responsibility, empowerment and recovery-oriented strategies. It is beneficial to the community-at-large by supporting collective advocacy, increasing networking and greater civic involvement, and improving awareness of and action on local issues and concerns. The comprehensive training curriculum allows consumers and family members to obtain skills

necessary for improving their quality of life, collective advocacy, proactive leadership, information sharing, and effectively leading groups of individuals to accomplish goals.

In FY 2012, the DCFA will continue to develop strategies to facilitate transformation to a person-driven, family-centered, community-based, results and recovery/resiliency oriented mental health system. Activities currently being considered include the development of an education and information campaign focused on recovery and empowerment**;** training all DMH service providers in the recovery model, person-centered planning, and System of Care principles/values and collaborating with other state and local level entities to promote recovery-oriented systems change. Additionally, in FY 2012 the Division will continue facilitating the incorporation of evidence-based recovery/resiliency practices and procedures across Bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers, and examine strategies that have been successful in other states in promoting recovery and consumer empowerment.

M. Use of Technology

The Department of Mental Health's Talk About It ICT (Interactive Communication Technology) Program offers individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. DMH has contracted with Ancomm, Inc. to provide this "text to talk" feature to all residents of Mississippi. DMH is also using this program to capture data and analyze trends related to the needs expressed by individuals accessing the site. DMH has utilized a media campaign to promote awareness of the service to the general population and has worked closely with the Department of Education and Institutes of Higher Learning to promote awareness to students in middle school, high school, and college. DMH will continue to conduct outreach and promotion in the coming years. By providing this service, DMH has increased access to services and supports and crisis intervention to an underserved population.

The MS Recovery and Resiliency Network is currently in the development phase but will provide a web based network to provide education and empowerment to individuals affected by mental illness, substance abuse, and intellectual and developmental disabilities. The interactive site will provide individuals an opportunity to learn about Personal Outcome Measures, Recovery and Resiliency, Individual Rights and resources. The network will also provide individuals with information concerning advocacy and training opportunities as well as highlight individuals creativity. The expected outcomes from this program include data collections, increased access to resources and information, and increased social connectedness. DMH will utilize a media outreach plan to publicize the network.

ICTs utilized by the Mississippi Transitional Outreach Program (MTOP) Initiative include text messaging, social networking, and web conferencing. Over the next two years, MTOP plans to promote an interactive website portal, web conferencing through the website portal, social marketing outreach through text, internet video, and email, and peer to peer social networking. Incentives planned to encourage the use of ICTs include gift cards, air time for cell phones, and participation on state and local advisory and leadership groups. MTOP plans to use program staff, Certified Peer to Peer transition-aged youth specialists, Certified Peer to Peer family involvement specialists, and free access to professionals in all state agencies to encourage the use of ICTs. Barriers to implementation of these efforts are educating individuals on the use of

ICTs, not because the technologies are difficult, but because they are different, and ensuring that individuals in rural communities can access these technologies. The MTOP Program will utilize ICTs to collect data for program evaluation accounting for who the consumers are and the participation of the providers. Data collection includes collection of demographics to indicate utilization of the technology, location of the user, and age of the user, frequency of use, and obtaining feedback on satisfaction or dissatisfaction with the technology as well as improvements that can be made to the process.

The Department of Mental Health has continued to make available case management orientation training for staff hired as case managers in the public community mental health system. In 2011 The Mississippi Department of Mental Health (DMH) announced the implementation of a new Internet-based staff training and development program - Elevate powered by Essential Learning. It is a customized training website for the Department of Mental Health that presents and tracks staff training requirements in an accessible and easy to use format. The Essential Learning training website will take the place of case management orientation and eliminate the need for extensive travel for case management credentialing.

The UMMC Department of Psychiatry and Human Behavior received a grant from the Delta Health Alliance and began implementing a telepsychiatry service with two sites in the Delta region in FY 2009. They initiated services in the fall of 2008 for two community mental health centers (in Greenwood and in Clarksdale). The telepsychiatry project received additional funding from the Delta Health Alliance during FY 2010 to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. During this past fiscal year they were able to connect all community mental health centers and their satellite sites in that region. They purchased additional equipment for the telepsychiatry unit based at MS State Hospital to provide continuity of care for those individuals admitted to the MS State Hospital from the designated Delta community mental health centers. The Department of Psychiatry has used the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing for substance abuse treatment). In addition, the Department of Psychiatry is looking into ways of sponsoring educational activities for other community mental health centers and state hospitals through the telehealth system.

N. Support of State Partners

Role of Other State Agencies in the Delivery of Behavioral Health Services

In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care. Representatives from various State agencies participate on the Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. Letters of Support from the Division of Medicaid, the Mississippi Department of Education, the Mississippi Department of Human Services, the Mississippi Department of Health, the Mississippi Department of Rehabilitation Services and the MOU for the Interagency Coordinating Council for Children and Youth (ICCCY) are included in Appendix B: Letters of Support and Interagency Coordinating Council for Children and Youth (ICCCY) Memoranda of Understanding. These State agency partners provided the following information:

Division of Medicaid, Office of the Governor (lead agency)

All children on Medicaid are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which include offering medical and dental services from Medicaid providers of those services if needed, as part of the treatment component of the EPSDT process. DMH Operational Standards also require that residential programs for children with serious emotional disturbance have in place plans for providing medical and dental services.

Mississippi Health Benefits is a cumulative term for the programs available for uninsured children. These include traditional Medicaid and the Children's Health Insurance Program The same application is used by individuals to apply for Mississippi Medicaid and CHIP. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP. Applications and redeterminations can be made at the 30 Regional Medicaid Offices, as well as additional outstation locations. Outstation locations include: local health departments, hospitals, and Federally Qualified Health Centers.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for a Community-based Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) program, one of 10 PRTF Demonstration Projects approved that year by the federal Centers for Medicare and Medicaid Services (CMS). The name of the program is Mississippi Youth Programs Around the Clock (MYPAC). Funds from this grant have assisted Mississippi in developing home- and community-based alternatives to residential treatment or institutionalization and significantly assist Mississippi in further developing and implementing a strong infrastructure, particularly for the one to three percent of the population with the most intensive needs targeted. The maximum unduplicated count of youth to be served through the program over the five-year project is 1970. Programs approved for funding under this demonstration grant include 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and wrap around teams that develop individual service plans. The outcomes from the MYPAC program are expected to be shorter lengths of stay at PRTFs, a decrease in PRTF beds over time, more coordinated treatment for youth with Serious Emotional Disturbance (SED), a reduction in the overall cost to the State, and an improved system of care for youth with SED.

The Department of Mental Health is continuing to work with the Division of Medicaid to develop a proposed State Plan Amendment and/or a waiver for submission to the Centers for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community based services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Bureau of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults.

In February 2011, the Mississippi Division of Medicaid was one of 13 states awarded the Money Follows the Person demonstration grant. The state will receive $37 million over the next six years. The Department of Mental Health has worked closely with the Division of Medicaid to assist in this effort. It is anticipated that demonstration will increase the ratio of community-based service spending compared to institutional spending over the course of the six-year grant. Cost savings achieved by transitioning people out of institutions will be directed into community-based services. This will help to eliminate barriers that prevent or restrict flexible use

of Medicaid funds and enable individuals to receive long-term care in the setting of their choice. The goal of the demonstration project is to help 595 persons with disabilities or the elderly transition out of institutions by 2017.

Mental Health and Substance Abuse Services for Children: Mississippi Department of Mental Health, Bureau of Mental Health, Bureau of Community Services, Division of Children/Youth Services and Bureau of Alcohol and Drug Abuse Services

Substance abuse services for adults and children are administered by the MS Department of Mental Health, Bureau of Alcohol and Drug Abuse (BADA). Community mental health centers, free-standing programs and two state-operated psychiatric hospitals are the primary providers of substance abuse treatment. The existing substance abuse treatment system components administered by the Bureau of Alcohol and Drug Abuse that address the needs of adults are described below:

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continues to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continues to certify 9 free-standing programs which also provide these services. One of the free-standing programs, Metro Counseling Center provides day treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care.

Intensive Outpatient Services: These services are directed to persons who need more intensive care but who have less severe alcohol and drug problems than those housed in residential treatment. IOP services enhance personal growth, facilitate the recovery process and encourage a philosophy of life which supports recovery.

Chemical Dependency Unit Services: Inpatient or hospital-based facilities offer services to these individuals with more severe substance abuse problems and who require a medically-based environment. Treatment includes detoxification, individual, group and family therapy, education services and family counseling. BADA continues to make funding available.

Primary Residential Services: These services are for persons who need intensive residential treatment who are addicted to alcohol and drug problems. Services are easily accessible and responsive to the needs of the individual. In residential treatment, various treatment modalities are available, including individual and group therapy; family therapy; education services; vocational and rehabilitation services; recreational and social services. Adolescents who need primary residential treatment for alcohol and drug problems are provided intensive intervention. Individual, group and family counseling are offered as well as education programs at the appropriate academic levels. Adults and adolescents with a co-occurring disorder of mental illness and substance abuse are also provided treatment in a primary residential setting.

Transitional Residential Services: These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program

before being eligible for admission to a transitional residential program.

Outreach/Aftercare Services: Outreach services provide information on, encourage utilization of, and provide access to needed treatment or support services in the community to assist persons with substance abuse problems or their families. Aftercare services are designed to assist individuals who have completed primary substance abuse treatment in maintaining sobriety and achieving positive vocational, family and personal adjustment.

Referral Services: The Bureau of Alcohol and Drug Abuse updates and distribute the current edition of the Mississippi Alcohol and Drug Prevention and Treatment Resources directory nationwide. The directory is also on the DMH Internet web site for those in need of services.

Employee Assistance Program: The Employee Assistance Coordinator updates and distributes the Employee Assistance Handbook to representatives of state agencies and organizations. The handbook entails the development of an employee assistance program including federal and state laws regarding a drug free workplace. The coordinator continues to provide EAP trainings across the state.

Specialized/Support Services: These services include vocational rehabilitation which is provided to individuals in local transitional residential treatment programs through a contract between the Bureau of Alcohol and Drug Abuse and the Department of Rehabilitation Services. Other specialized/support services include providing treatment to individuals who have been diagnosed with a co-occurring disorder of mental illness and substance abuse. The substance abuse treatment system also includes special programs or services designed specifically to target certain populations such as women and children, DUI offenders and state inmates.

Social Services/Protective Services: Mississippi Department of Human Services, Division of Family and Children's Services

Social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The DHS Division of Family and Children's Services provides child protective services, child abuse/neglect prevention, family preservation/reunification, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The DHS Division of Family and Children's Services and the Division of Youth Services work closely with the Department of Mental Health through participation on the MS State Mental Health Planning Council, MAP teams and other committees. The DHS Division of Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program, Health Marriage Initiative, Supplemental Nutrition Assistance Program (SNAP), the Emergency Food Assistance Program (TEFAP), SNAP Nutrition Education, and the "Just Wait" Abstinence Education program. The DHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, and oversees the state training schools. The DHS Division of Child Support provides child support location/enforcement services, and non-custodial visitation programs. The DHS

Division of Children and Youth provides certificates for child care services for TANF clients, child welfare clients and some working foster parents. The DHS Division of Aging and Adult Services (DAAS) plans, advocates for, and coordinates the delivery of services to adults 60 years of age and older through a system of local Area Agencies on Aging (AAAs). The DAAS's goal is to provide support services to help people remain in their own homes and local communities. The DAAS developed a single point of entry system for the aged and adult population with disabilities: the Aging and Disability Resource Center, called Mississippi Get Help. The project was piloted in central Mississippi and is scheduled to expand statewide with a toll-free, telephonic, virtual web-based, and face-to-face resource center that provides access to information, as well as assistance in applying for services. The "no wrong door" approach assures the public consistent information and assistance. In addition, it helps the public navigate through what can seem like a maze of government assistance, as well as the private and nonprofit service system. The Division of Aging and Adult Services also investigates abuse, neglect and exploitation of vulnerable adults, ages 18 and older in private settings under the Adult Protective Services program. The DHS Division of Community Services provides services such as the Fatherhood initiative, homeless resource referrals and low income utility assistance. Additional social services and financial assistance are accessed as needed for adults with serious mental illness and are administered through various public service agencies/organizations, such as the MS Department of Human Services (described above), the Division of Medicaid, the Department of Health, the Social Security Administration, the Cooperative Extension Service, the Salvation Army, churches, etc. Examples of this assistance include SNAP benefits, medical/other financial assistance, nutrition services, protective services, transportation, financial counseling, etc.

Justice Services: Mississippi Department of Human Services, Division of Youth Services; Mississippi Office of the Attorney General; Mississippi Department of Public Safety, Office of Justice Programs; Mississippi Youth Court Judges Association

The DMH has an agreement with the MS Department of Public Safety to provide professional mental health staff from the CMHCs to provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. DMH certified trainers from throughout the state have continued to conduct either the recruit or in-service training.

In FY 2011, DMH made funding available to 15 CMHCs to help support provision of law enforcement training. Twelve CMHCs applied for and received funding for law enforcement training. As of June 2011, CMHCs reported conducting 17 training sessions, with 446 law enforcement officers trained. This funding has been made available again in FY 2012 and 12 CMHCs have applied for and received the funding.

Hinds County continues its efforts to establish a CIT program. A group with representatives from UMC, Hinds Behavioral Health, Hinds County Sheriff's Department and the Jackson Police Department will receive train-the-trainer instruction from the Memphis CIT Program in early FY2012.

Lauderdale County has established the Lauderdale County Community Partnership to develop a CIT program in Meridian. The partnership includes members from Lauderdale County Sheriff's Department, Meridian Police Department, Weems Community Mental Health Center, Alliance Health Center, Rush Hospital, Riley Hospital, Anderson Regional Medical Center, NAMI, and

DMH. The Partnership has applied for funding from the Bureau of Justice Assistance (BJA) and is moving forward with planning.

The City of Hattiesburg with assistance from Pine Belt Mental Health (PBMH) established the state's first behavioral health court in FY2011. The Hattiesburg Behavioral Health Court (HBHC) also receives funding from BJA and received the "Excellence Award in Public Safety" from the Mississippi Municipal League. PBMH is now assisting the City of Purvis in establishing a behavioral health court through the same grant application from BJA.

Educational Services: Mississippi State Department of Education

Programs that provide services for children with mental health needs are available and accessible in the regular education setting as well as the special education arena. In Mississippi, there are fifteen (15) Regional Mental Health Centers (RMHC), with each location being responsible for provision of services to local school districts via interagency agreements. All fifteen RMHCs are required to have interagency agreements with each local school district in their region. As a result of this agreement, the number of students receiving services for assistance with emotional and behavioral disturbances while attending general and/or special education is approximately 33,350. Statewide initiatives such as those on suicide prevention, bullying, cybercrime (Sexting) have also played a large role in providing assistance to all students.

In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning. Section 504 Teacher Units are also approved through the Department of Education to local school districts for community residential programs for adolescents with substance abuse problems and other areas under Section 504 criteria. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. Children with serious emotional disturbance who meet eligibility criteria for a disability in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. A free appropriate public education (FAPE) must be available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP). After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment. Those services could include a functional behavioral assessment, behavioral intervention plan, and other positive behavioral interventions and supports determined by the IEP Committee. Each district must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities who reside within their jurisdiction for the provision of special education and related services. It is the IEP Committee that determines the appropriate special education and related services (including transition services) and placement of student with

disabilities. Any related service required by a student necessary to benefit from their special education services and any transition services determined appropriate by the IEP Committee must be provided at no cost to the parent. These related services include, but are not limited to: communication services, counseling services, physical therapy, occupational therapy, behavior interventions, assistive technology evaluations and devices, parent education and training, adapted physical education and transportation. All districts in the State must provide all services as determined by the IEP Committee.

Updated at least annually, the IEP must include a statement of the transition services needs of the child, beginning at age 14 (or younger, if determined appropriate by the IEP Committee). These transition services include coordination of services with agencies involved in supporting the transition of students with disabilities to postsecondary activities. Transition activities could include instruction, related services/training, community experiences, adult living/employment skills and when appropriate, acquisition of daily/independent living skills and functional vocational evaluation. Community-based activities, including job shadowing, on-the-job training, as well as part-time employment, are also provided if determined appropriate by the IEP Committee. The IEP must also have a desired post-school outcome statement. This statement should address areas of post-school activities/goals, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living and/or community participation.

Students Ruled EMD under the Individuals with Disabilities Education Act of (2004)

IDEA 2004 defines emotional disturbance as a condition in which a child exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: inability to learn that cannot be explained by intellectual, sensory or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behavior or feelings under normal circumstances; general pervasive mood of unhappiness or depression; and/or tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia and does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Other Educational Services and Initiatives

The Division of Parent Outreach within the Mississippi Department of Education, Office of Special Education (OSE), provides information and training in areas of identified need to parents, students, and community organizations. This division works to build collaborative relationships with parents and organizations interested in services to children with disabilities. This division also provides the following: training regarding parental rights and services under IDEA 2004; development and distribution of materials for parents; handling of parent complaints, mediation, Resolution Sessions, and due process hearings; and conducting meetings with stakeholders.

The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling. Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses

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

Dental/Health Services: Mississippi State Department of Health and Division of Medicaid

Health/Medical/Dental Services are accessed through case management for children of all ages with serious emotional disturbance. These services are provided through a variety of community resources, such as through community health centers/clinics, county health department offices, university programs and services and private practitioners.

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 165 service delivery sites in Mississippi serving approximately 310,000 patients and further advancing President Obama's effort to provide access to health care for all Americans. Community Health Centers are located in high need areas identified as having elevated poverty, higher than average infant mortality, and where few physicians practice. These health centers tailor services to meet the special needs and priorities of their communities. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers who provide high quality care, thus reducing health disparities and improving patient outcomes. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale. However, no one is refused care due to inability to pay for services. These community health centers provide cost effective care and reduce emergency room, hospital and specialty care visits, thus saving the health care system between $9.9 and $17.6 billion a year. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

The MS Department of Health (DOH) also makes available certain Child Health Services statewide to children living at or below 185 percent of the non-farm poverty level and to other children with poor access to healthcare. The Child Health services include childhood immunizations, well-child assessments, limited sick child care, and tracking of infants and other high risk children. Through other internal programs and community initiatives, the Department of Health works to address issues such as teen pregnancy, tobacco use, unintentional injuries, and promotes specific interventions to decrease infant mortality and morbidity. Services are preventive in nature and designed for early identification of disabling conditions. Children in need of further care are linked with other State Department of Health programs and/or private care providers necessary for effective treatment and management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age.

Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. DOH partners with other state agencies and organizations to address child and adolescent issues through active participation with, but not limited to, the local MAP teams, State Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

Included in the CHIP program is coverage for dental services, which includes preventive, diagnostic and routine filling services. Other dental care is covered if it is warranted as a result of an accident or a medically-associated diagnosis. During the 2001 Legislative Session, legislation was passed authorizing the expansion of dental coverage in CHIP Phase II, which was effective January 1, 2002. The expanded dental benefit includes some restorative, endodontic, periodontic and surgical dental services. The establishment of a dental provider network was also authorized, making dentists more accessible. Historically, there has been poor participation by dentists in the State Medicaid program due to low reimbursement rates primarily. House Bill 528, passed in the 2007 Legislative Session and signed by Governor Barbour establishes a fee revision for dental services as an incentive to increase the number of dentists who actively provide Medicaid services. A new dental fee schedule became effective July 1, 2007, for dental services. In addition, a limit of $2500 per beneficiary per fiscal year for dental services and $4200 per child per lifetime for orthodontia was established, with additional services being available upon prior approval by the Division of Medicaid.

The Mississippi Department of Health's Office of Oral Health assesses oral health status and needs and mobilizes community partnerships to link people to population-based oral health services to improve the oral health of Mississippi children and families. The Mississippi Regional Oral Health Consultants are licensed dental hygienists in each Public Health District who perform oral health screening and education and provide preventive flouride varnish applications to prioritized populations, such as children enrolled in Head Start programs. The Public Water Fluoridation Program is a collaboration with the Bower Foundation to provide grant funds to public water systems to install community water fluoridation programs.

The Mississippi State Department of Health (MSDH) recommends that every child begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. The MSDH Office of Oral Health can provide guidance on how to perform an oral health risk assessment and several risk assessment tools are available through the American Academy of Pediatrics, the American Association of Pediatric Dentistry, and the American Dental Association. Groups at higher risk for having dental caries, or tooth decay, include children with special health care needs, children of mothers with a high dental caries rate, children with demonstrable dental caries, plaque, demineralization, and/or staining, children who sleep with a bottle or breastfeed throughout the night, later-order offspring, and children in families of low socioeconomic status. The MSDH recommends that infants in risk groups should be referred to a dentist as early as 6 months of age and no later than 6 months after

the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home with education and early prevention services.

The Primary Health Care Association reports that the availability of dental care and oral health care for underprivileged individuals has increased in communities where federally-funded Community Health Centers are located. Currently 19 of the 21 Community Health Centers (CHCs) offer oral health services. Two of the CHCs receive federal funding to provide health care to the homeless populations, focusing on mental health and substance abuse, in addition to medical care. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

Health/Medical/Dental Services are addressed by community mental health centers with other support services to adults with serious mental illness as part of local CSP plans, which are required as part of local providers' applications for CMHS block grant funds. CMHCs provide medical and dental services in a variety of ways, with the primary avenues being: 1) use of community health centers; 2) use of State Department of Health county health offices/services; 3) pro bono work by physicians and dentists; 4) University Medical Center services; 5) contributions by mental health associations and other local nonprofit/charitable organizations; 6) emergency medical/dental funds maintained by the provider program, including DMH funding for purchase of psychotropic medications; and 7) contributions by individuals and businesses. Of course, some medical and dental services are paid through the Medicaid and Medicare programs.

The MS Department of Health (MSDH) also makes available certain specialized health care programs. Through other internal programs and community initiatives, MSDH works to address issues such as teen pregnancy, tobacco use, and unintentional injuries, and to promote specific interventions to decrease infant mortality.

Outpatient mental health services are also available through licensed practitioners in the private sector, whose scope of practice and services are regulated by their respective licensure boards/agencies and payors of their services (insurance programs, Medicaid, etc.). The Department of Health, which collects data on private psychiatric facilities it licenses, reported 242 licensed and/or CON approved inpatient beds for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units) and 540 licensed/inpatient beds, with an additional seven beds held in abeyance and 34 CON approved beds by MSDH for psychiatric services for adults in FY 2010. The Department of Health also collects data on private chemical dependency treatment facilities it licenses and reported 52 licensed and/or Certificate of Need (CON) approved beds in FY 2010 for adolescents and 288 licensed and/or Certificate of Need (CON) approved beds in FY 2010 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

The University of Mississippi Medical Center (UMMC), Department of Psychiatry and Human Behavior has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for senior psychiatry residents has been established in the public community

mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Clinical psychology residents and faculty are collaborating with Harbor House (nonprofit community treatment program for adults with substance abuse problems); psychology residents and child psychiatry residents also have clinical rotations at Mississippi Children's Home Society/CARES, a nonprofit program serving youth. Additionally, two UMMC child psychiatrists and fellows provide services at the Oakley Training School, and plans are under development regarding provision of psychiatric services via telehealth by UMMC clinical staff to a facility operated through the Mississippi Department of Corrections.

Rehabilitation Services: Mississippi Department of Rehabilitation Services

Rehabilitation services are available to youth (within the last two years of exiting high school) through the Office of Vocational Rehabilitation and Vocational Rehabilitation for the Blind in the Mississippi Department of Rehabilitation Services, in accordance with federal eligibility criteria and guidelines. General vocational rehabilitation services include a range of services from diagnosis and evaluation to vocational training and job placement. Additionally, a youth eligible for general vocational rehabilitation services might receive assistance with medical and/or health needs, special equipment counseling or other assistance that would enhance employability for a specific vocational outcome. Other specialized vocational rehabilitation services can also be accessed based on the youth's potential for a specific vocation. Supported employment, a specialized vocational rehabilitation service, is available to youth and adults who demonstrate more severe disabilities and who need ongoing job support to retain employment.

A representative of the Mississippi Department of Rehabilitation Services continued to attend State-level Interagency Case Review/MAP Team meetings. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, also participated on the Transitional Services Task Force and provided members with information on meeting the employment needs of youth in the transitional age range (18 to 25 years). The Executive Director of the Department of Rehabilitation Services continues to serve on the state executive-level Interagency Coordinating Council for Children and Youth (ICCCY) a representative continues to participate on the mid-management state level Interagency System of Care Council/ISCC (legislatively authorized in same legislation authorizing the ICCCY).

Specific examples of vocational/employment services accessed for youth by individual children's community mental health service providers include: independent living skills training, occupational therapy and development, GED programs, job training and placement, interviewing training, life skills assessment, supported employment, job coaching, , work readiness programs, basic technical skills training, resume and application assistance, and technology training. These services are provided through a variety of state and local resources and providers, which can vary across communities, such as: Job Corps, the Mississippi State Employment Security Commission, WIN Job Centers, the Mississippi Department of Rehabilitation Services, local school districts, Recruitment/Training Program of Mississippi, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, AbilityWorks, Inc. of Mississippi, county vocational-technical centers, Youth Challenge Program, the Mississippi Department of Human Services, MIDD, MIDD West Industries, Pine Belt Mental Healthcare Resources Transitional Outreach Program, Pine Belt Graphics, PALS,

Youth Challenge, Jackson State University, and community colleges.

DMH minimum standards require that transitional employment programs be available as part of clubhouse programs. In addition to transitional employment programs offered by the CMHCs, individuals with serious mental illness have access to other VR services through referral(s) with VR service entities.

General vocational rehabilitation services are available to individuals with serious mental illness through referral to the Office of Vocational Rehabilitation in the Mississippi Department of Rehabilitation Services. Once an individual's eligibility for services is established (as per eligibility criteria and guidelines of the Office of Vocational Rehabilitation), services are provided on an individualized basis, pursuant to a formal plan developed with the eligible individual. General vocational rehabilitation services include a range of services from diagnosis and evaluation to vocational training and job placement. Individual referrals can be made to VR/Supported Employment counselors who utilize VR case service funds to pay for services outlined on the Individualized Plan for Employment (IPE), which could include Job Coaches, Job Development and other services. These VR/Supported Employment counselors work for the Mississippi Department of Rehabilitation Services, and it should be noted that such referrals for services usually, but do not always, result in the use of job coaches. The DMH hopes the use of job coaches or other employment support options for individuals with mental illness will increase; this program component, however, is under the supervision and regulations administered by the Mississippi Department of Rehabilitation Services. Additionally, individuals eligible for general vocational rehabilitation services might receive assistance with medical and/or health needs, special equipment, counseling, educational training, or other assistance that would enhance employability.

The Department of Mental Health plans to continue increased collaboration with MS Department of Rehabilitation Services staff to explore options for expanding supported and competitive employment options for individuals with serious mental illness that might be available through that agency. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, has continued to participate on the Transitional Age Services Task Force and provided members with information on meeting the employment needs of youth/young adults in the transitional age range (14 to 25 years). The Office of Vocational Rehabilitation also participates on the Transportation Coalition. The DMH Division of Community Services has a representative on the board of APSE, Mississippi Advancing Employment Connecting People, MS APSE, which held its second conference, Opening Doors to Employment…Making It Happen.

Representatives of the Mississippi Department of Rehabilitation Services including the Program Coordinator of the Selected Social Security Services Division at the Mississippi Department of Rehabilitation Services (MDRS) and coordinator of the Work Incentives Planning and Assistance project administered by MDRS, Mississippi Partners for Informed Choice (M-PIC), and the Ticket to Work Program have served as an additional resource for employment support. The Ticket to Work Program is the centerpiece of federal legislation signed into law in December 1999 under the Ticket to Work and Work Incentives Improvement Act of 1999. The legislation is designed to increase choices for SSA beneficiaries in obtaining rehabilitation and vocational services; to remove barriers that required people with disabilities to choose between health care coverage and work; and, to assure that more disabled beneficiaries with disabilities

have the opportunity to work. One of the key provisions of the Ticket legislation is the Ticket to Work Program, which requires the Social Security Administration to issue tickets to SSA beneficiaries with disabilities. These tickets may be used to obtain vocational rehabilitation, employment, or other support services from an approved provider of their choice. The Social Security Administration's final regulations for the Ticket to Work Program were published in the May 20, 2008, Federal Register and became effective July 21, 2008.

For the past eleven years, the Mississippi Partners for Informed Choice (M-PIC) program has provided Work Incentives Planning and Assistance (WIPA) services to individuals receiving Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability. Work incentives planning and assistance services are provided free to these recipients through the program in order to enhance their ability to make informed choices regarding reentry into the workforce or entry into the workforce for the first time. M-PIC has Community Work Incentives Coordinators (CWICs) working in designated regions of the state who are available to comprehensively demonstrate the effect of wages on the SSDI/SSI recipient's disability benefits to dispel any unjustified fears of benefit loss due to work. The CWICs will work closely with the Social Security Administration, the Mississippi Department of Rehabilitation Services, other federal and state agencies and community service agencies, as needed, in order to maximize work incentives. Services under WIPA are designed to: analyze the impact of work and earnings on disability benefits; enhance individuals' ability to make informed choices in transitioning from benefits to work; identify work incentives to help achieve work goals; advise on how and when to use the Ticket to Work**;** assist in developing a plan for employment; coordinate with other agencies regarding a plan for employment; and, refer to other agencies that may provide additional supports to better enable the transition to work.

Given the potential benefit of services provided by the Mississippi Partners for Informed Choice to individuals with serious mental illness who are SSI and/or SSDI recipients, as well as the impact of the Ticket to Work Program changes, staff from the Mississippi Department of Mental Health and the Department of Rehabilitation Services, Division of Selected Social Security Services have partnered to provide a series of educational presentations on these rehabilitation services topics. MDRS staff will continue to make available information through presentations and exhibits for mental health staff and consumers. For their service areas, M-PIC staff provided training and educational information to local mental health center staff and individuals with mental illness throughout the state. DMH staff has facilitated linkage with MDRS staff to increase collaboration of local providers and consumer education programs as part of the agencies' outreach efforts. MDRS's Division of Selected Social Security Services staff look forward to continuing their partnership with the DMH to provide support services to individuals with mental illness.

Educational Services may also be accessed by community mental health centers for some adults with serious mental illness. These services generally include GED and adult literacy, and/or vocational training programs provided through community colleges, local schools, and/or volunteer organizations. Specific Vocational/Employment/Educational Services are provided to adults with serious mental illness, in addition to or in conjunction with vocational rehabilitation services and consumer education programs.

Protection and Advocacy: Disability Rights Mississippi

Disability Rights Mississippi is a private, nonprofit corporation established to protect and advocate for the rights of individuals with disabilities through negotiation, legal, and administrative remedies. Disability Rights Mississippi is independent of any agency, organization or governmental unit providing treatment, services, or habilitation to individuals with disabilities. The staff is also responsible for providing public information concerning the rights of individuals with mental illness and developmental disabilities and will assist professional and citizen groups by providing workshops on the rights of individuals with disabilities, including mental illness. A Board of Directors governs the agency. The purpose of Mental Health Advocacy Services within Disability Rights Mississippi is to protect and advocate for the rights of persons with mental illness. Services provided through the program include information and referral; technical assistance; advice and support for persons who plan to advocate for themselves, their rights and needed services; assistance in meetings and negotiations; representation in administrative appeals and hearings; and litigation of cases, where the outcome could benefit many individuals. Additional services designed to enhance the rights of all persons labeled mentally ill include: public information and education regarding the needs and rights of persons labeled mentally ill; monitoring of state institutions and private and public psychiatric hospitals; and identification of problems in the system of service delivery and advocacy to improve the service delivery system. It provides advocacy and legal assistance to persons with mental illness living in a variety of settings, including jails, personal care homes, detention facilities, group homes, nursing homes and those living independently.

Mississippi Families As Allies for Children's Mental Health, Inc.

Division of Children and Youth continues to provide financial support and technical assistance to Mississippi Families As Allies, Inc., (MS FAA). MS FAA has built a statewide parent support, education and advocacy network for families of children who have emotional/behavioral difficulties or mental illness. Funding from the Department of Mental Health continues to help support the employment of a full-time Family Crisis Specialist and to support respite services to care givers, while also providing support for administration and clerical services, training, and family service expansion.

Major goals of the MS FAA are to enhance and develop levels of emotional support available to families, to provide a systematic, structured process for the transfer of knowledge for families and professionals and to provide external advocacy for service development. Services offered through this growing network include: a toll-free number for easy access to the main office and to local MS FAA Chapters; support and case advocacy for families and children via Family Partners; information and referrals; educational forums and workshops; a resource library of materials about children with emotional or behavioral problems; FACTS for Families, available on the MS FAA website and by mail; leadership training and education for parents and youth. The Division of Children and Youth Services continues to refer individuals and service providers requesting information on available family education/training to MS Families as Allies for Children's Mental Health Services, Inc. MS FAA is also the official administrator for training, services and quality assurance for in-home and group respite.

Under the Statewide Family network grant, MS FAA Family Partners provide technical assistance to families on developing their own network and leadership capacity. This

support helps families participate on MAP Teams and make improvements to their own local Systems of Care. In this way, MS FAA integrates its Family Education, Family Support and Local Network Development initiatives funded with federal resources. MS FAA has continued to support families' participation in local, regional and national workshops and conferences via parent stipends, child care and respite services, and funding of registration and travel costs, as funding is available.

O. State Behavioral Health Advisory Council

See Appendix C for a letter from the Chairperson of the Mississippi State Planning and Advisory Council indicating the Council's participation in the development, monitoring, reviewing, and evaluation of the Mental Health Block Grant State Plan.

List of Advisory Council Members

Table 11 Plan Year: 2012-2013

Name	Type of Membership	Agency or Organization Represented
Ms. Ann Moore	Education (State Employee)	MS Department of Education
Mr. Lee Alderman	Vocational Rehabilitation (State Employee)	MS Department of Rehabilitation Services
Ms. Kim Richardson	Criminal Justice (State Employee)	Victim Coordinator, MS Bureau of Investigation
Dr. Gloria E. Adams	Housing and Homelessness (State Employee)	Bureau Director, Division of Community Services, Mississippi Development Authority
Ms. Sandra McClendon	Social Services (DHS) (State Employee)	Resource Development Director, Div. of Family and Children's Services, MDHS
Ms. Bonlitha Windham	Medicaid (State Employee)	Division of Medicaid
Ms. Maris Cooper	MS Insurance. Dept. Examiner (State Employee)	Insurance Examiner
Ms. Suzanne Lancaster	Office of the Governor; (State Representative)	Warren-Yazoo Mental Health Services Dir. Children's Serv.
Children are served across	**agencies - no single child agency**	State Child Serving Agency
Mr. James Chastain Director	Mental Health (State Employee)	Director, MS State Hospital
Ms. Debbie Ferguson	Mental Health (State Employee)	Director, Central MS Residential Center
Dr. Janette McCrory	Higher Education (State Employee)	Institutions of Higher Learning
Dr. Namita Khanna Arora	Community Mental Health Center (Provider)	Warren-Yazoo Mental health Services, University Medical Center
Maxie Lerone Gordon, M.D.	Mental Health (Provider)	MS Psychiatric Association
Mr. Greg Patin	Mental Health (Provider	Executive Director;

	Children)	Catholic Charities, Inc.
Mr. Charlie Spearman, Sr.	Community Mental Health Center (Provider)	Executive Director; Region IV, Timber Hills Mental Health Services
Ms. Sandra Caron (Secretary)	Individual	NAMI-MS Coordinator of Consumer Programs, MS Peer Leadership Network
Ms. Amanda Clement (Vice Chairperson)	Individual	Self; Chair, Consumer Rights Committee
Ms. Myrna Douglas (Parliamentarian)	Individual	Self; Member, Consumer Rights Comm.; Long Range Planning Committee
Ms. Jan Downer	Individual	Self; Member Long Range Planning Committee
Mr. Daniel Litland	Individual	Self
Mr. Rafiq H. Mateen	Individual	Self; Member MS Mental Health Consumer Coalition
Ms. Veronica (Nikki) Stone	Individual	Self
Ms. Sonia Bartosek	Family Member (Child)	Self
Ms. Annette Giessner	Family Member (Adult)	Self
Mr. Bill Kehoe	Family Member (Adult)	Self
Ms. Tara D. Manning	Family Member (Child)	MS Families As Allies for Chldren's Mental Health, Inc.
Ms. Harriette P. Mastin	Family Member (Adult)	Self: Member NAMI Board; Member Warren-Yazoo Advisory Council; Support Group Leader MS Advisory Coalition; Provider Education Teacher Visions Family to Family
Ms. Oleta R. Maury	Family Member (Child/Youth)	Self; Member Children's Services Task Force
Ms. Alicia Moberg	Family Member (Child)	Self
Ms. Elaine Owens	Family Member (Adult)	Self
Ms. Diowanni Tate	Family Member (Child)	Director Family & Youth Services MS Families as Allies for Children's Mental Health, Inc.
Ms. Tonya Tate	Family Member (Adult)	Executive Dir. NAMI MS
Mr. Larry Waller (President)	Family Member (Adult)	Self
Ms. Debra Wertz	Family Member (Child)	Self; MS Children's Home Society; CARES
Chaney, Hon. Mark	MS A& D Advisory Council Other	MS A& D Advisory Council
Daneault, Ms. Kay	Other	Executive Director, Mental Health Association of MS
Dr. Debbie J. Holt	Other	Clinical Educator for Domestic Violence Lutheran Episcopal Services
Ms. Sarah Marshall	Other	Nurses Association
Ms. Linda Raff	Other	Long Range Planning Committee Chair

Ms. Karla Tye	Other	Executive Dir. Children's Advocacy Centers of MS

BEHAVIORAL HEALTH ADVISORY COUNCIL COMPOSITION BY TYPE OF MEMBER

Table 12 Plan Year: 2012-2013

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	41	
Individuals in Recovery	7	
Family Members of Individuals in Recovery (1)	12	
Vacancies (individuals & family members)	0	
Others (Not State employees or providers)	5	
TOTAL Individuals in Recovery, Family Members & Others	24	59%
State Employees	11	
Providers	4	
Leading State Experts (2)	0	
Federally Recognized Tribe Representatives (3)	0	
Vacancies (3)	1	
TOTAL State Employees & Providers	16	37%

(1) A representative of Mississippi Families as Allies for Children's Mental Health (MS FAA) was listed as a family member representative since MS FAA is the statewide education/advocacy organization for parents of children with serious emotional disturbance.

(2) (a) A representative of the Mississippi Insurance Department, which at this time is the primary state agency leading efforts to develop an insurance exchange, was recently added; this individual is counted as a state employee.

(b) A representative of the Mississippi Alcohol and Drug Abuse Advisory Council was recently appointed to serve on the Mississippi Mental Health Planning and Advisory Council to facilitate coordination between these two entities. This representative is listed under "Other." Coordination efforts across substance abuse prevention and treatment and mental health services are described under steps 3 and 4.

(3) Communication has been initiated with the Mississippi Band of Choctaw Indians for appointment of their representative, which is anticipated to be finalized during the next several weeks.

P. Comment on the State Plan

The Council was provided an initial draft of the *FY 2012-2013 Plan* prior to their meeting in June, 2011. The Council's procedures for presentation of priorities to be addressed were followed, with presentations on major areas addressed in the draft plan presented for the Director of the Division of Community Services for Adults, the Director of the Division of Children and Youth Services and the Director of the Division of Consumer and Family Affairs in the Bureau of Community Services. Council members then asked questions and approved the draft plan to be sent out statewide for 30 days' additional public review and comment. The Draft Plan was also presented to the State Board of Mental Health, the governing authority of the Mississippi Department of Mental Health, for review at their July, 2011, meeting.

Public notices of the availability of *Draft Plans* for 30 days' public review and comment, from July 11 through August 9, 2011, were published in major *newspapers across the* state prior to the comment period. Public notices indicated that Draft Plans were available at the 15 regional community mental health centers across the state, the East MS State Hospital in Meridian, the MS State Hospital in Whitfield, the North MS State Hospital in Tupelo, the South MS State Hospital in Purvis, the Central MS Residential Center in Newton, the five regional centers for persons with mental retardation, the Specialized Treatment Facility and the Mississippi Adolescent Center operated by the Department of Mental Health and on the MS Department of Mental Health's website. A Draft Plan was sent directly to the directors of the community mental health centers and the Department of Mental Health facilities, asking them to make the Plan available to their employees and other interested individuals in their area of the state.

In addition to those entities listed in the public notice, the Draft Plan and requests for review, comment, and assistance in making the Plan accessible for review and comment were sent directly to Governor Haley Barbour and the directors of the following agencies:

MS Department of Education
MS Department of Health
MS Department of Human Services
MS Department of Human Services, Division of Aging and Adult Services
Disability Rights Mississippi, Inc. (formerly Mississippi Protection and Advocacy System, Inc.)

MS Department of Rehabilitation Services
MS Institutions of Higher Learning (governing authority of state universities)
Office of the Governor, Division of Medicaid
Mississippi Development Authority (agency responsible for Consolidated Plan for housing)
Department of Psychiatry and Human Behavior, University of MS Medical Center
MS Primary Health Care Association (community health centers organization)

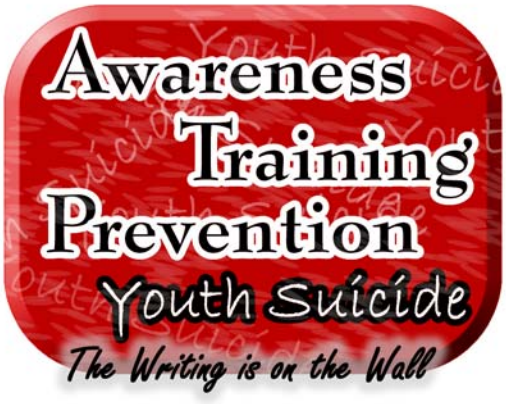
Although some non-service representatives on the Planning Council are also members of NAMI chapters, Mental Health Associations and/or Mississippi Families As Allies for Children's Mental Health, Inc., additional copies of the Draft Plan and requests for comment were also sent to directors, presidents, or other leadership of state and local affiliates of the following family/consumer/advocacy groups:

Mississippi Families as Allies for Children's Mental Health, Inc.
Mental Health Association of Mississippi
NAMI Mississippi

The Council met again on August 11, 2011, to discuss and review the final Draft FY 2012-2013 Plan, including proposed changes by the DMH staff, which included technical corrections and changes made by staff to comply with final SAMHSA/CMHS application guidance. Changes to the Draft Plan reviewed at that meeting and approved by the Planning Council will be incorporated by DMH in finalizing the FY 2012-2013 State Plan submitted to the State Board of Mental Health at its August 18, 2011, meeting and subsequently, to the Center for Mental Health Services (due September 1, 2011).

Copies of the final FY 2012-2013 State Plan will be disseminated to entities and individuals who received a Draft Plan (indicated above), directors of agencies/entities represented on the Council (if agency staff other than the director serves on the Council), and other individuals/entities who request a copy of the final Plan. The final FY 2012-2013 State Plan will also be available throughout the year on the DMH's website and through the state's depository libraries system.

Appendix A
Mississippi Youth Suicide Prevention Plan



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DIVISION OF CHILDREN AND YOUTH

Funded, in part, through a grant from Substance Abuse and Mental Health Services Administration, Department of Health and Human Services

MISSISSIPPI YOUTH SUICIDE PREVENTION PLAN
May 2007

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Mississippi Youth Suicide Prevention Plan

I. OVERVIEW

A. Introduction

In 2006, the MS Department of Mental Health, Division of Children and Youth, received a grant from the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, to develop and implement statewide suicide prevention and early intervention activities to benefit youth who were adversely impacted by Hurricane Katrina.

A part of the grant structure and governance was the development of a grant advisory council. Although the project's original intent was to strengthen the state's response to the mental health needs of youth ages 10-24 in six gulf coast counties most adversely affected by the storm, the newly established council subsequently supported and approved the development of a *state-wide* plan for addressing suicide prevention. In addition to the advisory council's duties and role of providing leadership and insight for the implementation of the Federal grant, this Mississippi Youth Suicide Prevention Advisory Council (Council) also developed Mississippi's first comprehensive plan for youth suicide prevention.

A professional services firm, the Parham Group, was retained to lead and guide the development of this first state-wide plan. The process used by the Parham Group included extensive research on national and state statistical data and suicidal causes, treatment, and awareness information; review of the National Strategy for Suicide Prevention, as well as other state plans; personal interviews with Council members; open discussions with the Council; correspondence with Council members; and review of draft plan documents with the Council.

B. Purpose

Approximately 349 Mississippians youth die each year from suicide. With a suicide rate of 12 per 100,000 population, Mississippi ranks 23 out of the 50 states (ranges from Alaska at 23/100,000 to DC with 6/100,000).Of these suicides, **54** are youth ages15-24, making suicide the **2nd** leading cause of death among this age group in the state. On average, there are 1,343 hospitalizations in Mississippi each year because of attempted suicide. Nearly 200 of these were youth ages 15-19. [1]

According to the 2005 Centers for Disease Control's *Youth Risk Behavior Survey***, 25%** of middle school- age children in the state reported seriously considering suicide (compared to the national average reported in the YRBS of 17%); **18%** of Mississippi middle school-age children reported making a plan to kill themselves (compared to the national average of 17%); and **11.7%** of middle school children reported that they had attempted suicide in the past 12 months (compared to national average of 8.5%). [2]

It is the intent that led and organized through this plan, Mississippi will have an increased capacity to better intervene and respond to its youth who are hurting to the point of taking/attempting to take their own lives, through increased awareness and understanding of this menacing problem threatening our youth. We hope to shed the stigmatism and silence surrounding it, increase the training of community "gatekeepers", and promote effective clinical and professional practice.

C. Target Population

The target population for this state-wide plan is adolescents and young adults, ages 10-24, in Mississippi.

D. Expected Outcomes

Ultimately, the goals of this plan are: (**1) a reduction in completed suicides by Mississippi youth by 2010; and (2) a reduction in youth hospitalizations resulting from suicide attempts by 2010**. Ideally, the most effective means of accomplishing these goals is to remove the underlying or root cause of the pain suffered by youth who seriously consider suicide. Realistically, however, this approach alone would not only be extremely difficult to implement, but would also take a very long time to have any meaningful impact – time that some youth idealizing suicide do not have. Therefore, this plan outlines ten (10) relatively short-term objectives that we feel, if implemented appropriately, will effectively move the state toward successful achievement of the identified goals.

II. Mississippi Youth Suicide Prevention Advisory Council Members

1. Kim Saggis, Jason Foundation
2. Dr. John Fontaine, Child Psychologist
3. Roderick Richardson, MS State Department of Health
4. Dr. Michael Mann, Assistant Professor, Psychology & Counseling, Mississippi College
5. Regina Ginn, State Department of Education
6. Kelly Wilson, Catholic Charities of Jackson
7. Patti Marshall, Office of MS Attorney General
8. Gwen Winters, State Department of Health
9. Sandra Parks, MS Department of Mental Health
10. Mardi Allen, Ph.D., MS Department of Mental Health
11. Erin Gallagher, Gulf Coast Mental Health Center
12. Teresa Mosely, Family Representative
13. Sharon Grisham-Stewart, Hinds County Coroner
14. Leslie Sullivan, Youth Representative

Advisory Members

1. Kris Jones, MS Department of Mental Health, Division of Disaster Preparedness & Response
2. Shelley Foreman, Gulf Coast Mental Health Center
3. Martha Garrett, Catholic Charities of Jackson
4. Jackie Chatmon, MS Department of Mental Health, Division of Children & Youth Services
5. Buddy Parham, Parham and Associates
6. Chelley Barnes, Mississippi Department of Education

III. Suicide- Related Facts and Information for Adolescents and Young Adults

A. Key Statistics: Nationally

- About 2 million adolescents attempt suicide each year in the US. Almost 700,000 of these require hospitalization resulting from their attempt. 19% of high school students reported they have considered suicide, 15% have made a plan to complete suicide, and about 9% of all high school students have attempted suicide. 3

- Suicide is the 3rd leading cause of death in the US for adolescents and young adults accounting for 11.2% (4,232) of all deaths for this age group. 4

- Young white males are much more likely to complete suicide than young black males and 5 times higher than peer females of any race. However, females are more likely to *attempt* suicide. Only American Indian/Alaskan Native males have a higher suicide rate (more than 2 times higher). Black females are the least likely to complete suicide in this age group. 5

- Within the age group, the suicide death rate for adolescents ages 10-14 is 1.7/100,000, for 15-19 year olds the rate is 8.9/100,000, and for 20-24 year old young adults, the suicide death rate is 13.6/100,000. 6

- Suicidal behaviors in young adults are usually the result of a process that involves multiple social, economic, family, and individual risk factors. More than 90% of all youth suicide victims have at least one major psychiatric disorder. 7

- Firearms (60%) and hanging (26%) were the two most common methods of suicide by youth ages 10-24. 8

- The most prevalent risk factors for suicide for adolescents and young adults are depression/hopelessness or other mental health issues, impulsive or aggressive tendencies, a sense of isolation, substance abuse, history of trauma or abuse, parental separation, and relational or social loss. Studies are showing that there is an increased risk for suicide among youth reporting gay/lesbian/bisexual orientation, especially for males. 9

Key Statistics: Mississippi

- In Mississippi, approximately 54 youth ages 15-24 complete suicide each year. 10

- Suicide is the 2nd leading cause of death in MS for this (15-24) age group. 11

- Reflecting the national statistics, males are much more likely (83%) to complete suicide in MS than peer females (17%). Similarly, 83% of all youth suicides in MS are completed by white youth (any sex). Thus, of the 54 deaths by suicide (15-24 age group) in 2005 in MS, 37,or 68%, were white male, 8 (15%) were white female, 15 (8%) were nonwhite male, and 1 (less than 2%) were nonwhite female. 12

- The use of a Firearm is the most common method of suicide as well. 13

B. Risk Factors for Suicide

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illness
- Family history of suicide
- Relational or social loss
- Easy access to lethal means
- Lack of social support and/or a sense of isolation
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Exposure to, including through the media, and influence of others who have died by suicide 14

C. Protective Factors for Suicide

- Effective clinical care for mental, physical, and substance use disorders.
- Easy access to a variety of clinical interventions and support for help-seeking.

- Restricted access to highly lethal means of suicide.
- Strong connections to family and community support.
- Support through ongoing medical and mental health care relationships.
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self-preservation. 15

D. Warning Signs for Teen and Young Adult Suicide

- Talks about committing suicide
- Has trouble eating or sleeping
- Experiences drastic changes in behavior
- Withdraws from friends and/or social activities
- Loss of interest in hobbies, school, activities
- Gives away prized possessions
- Had recent severe social/relational loss
- Is preoccupied with death and dying
- Loss of interest in personal appearance
- Increased use of alcohol or drugs 16

E. How to Help Someone Who is Thinking about Suicide

Suicide is not about wanting to die, but rather about a powerful need for pain to end. People choose suicide because they feel unable to cope with feelings of pain, hopelessness, helplessness, isolation, and uncertainties. Studies indicate that the best way to prevent suicide is through the early recognition and treatment of depression and other psychiatric illnesses that lead to suicidal tendencies. People who want to die by suicide almost always suffer from isolation and loneliness. You can help them simply by reaching out, listening, and letting them know you care. Often, with time and the help of others, suicidal feelings do pass. 17

Specific actions that may help if you know or suspect someone is considering suicide include:

- Be direct. Talk openly about suicide.
- Be willing to listen.
- Be non-judgmental.
- Get involved and be available.
- Don't act shocked.
- Offer hope of alternatives.
- Do not be sworn to secrecy. Seek help.
- Take action. Remove access to guns, stockpiled pills, or other threats. 18

IV. Identified Issues/Needs/Gaps/Problems:

- Lack of structured, organized, comprehensive effort that heightens the importance and urgency of addressing youth suicide prevention
- Lack of awareness about severity, causes, indicators, etc. associated with suicide by public, parents, youth
- Lack of understanding, knowledge, and skill of "gatekeepers" to identify and effectively intervene

- Lack of holistic, systemic protocol (procedure, process) to access appropriate resources needed address underlying risk factors
- Social stigma/shame of suicide, suicide attempts, suicidal ideation
- Social pressure of "not measuring up", fear of failing
- Involve youth more in prevention process (increase awareness and knowledge; web-based interactive tool for screening, assessing, and information sharing, how to intervene, etc.)
- Improve surveillance (statistical data collection and observation) regarding youth suicide and suicide attempts (to be more accurate, more information, etc.)

V. Focus Areas, Goals, Objectives, & Strategies

As a result of the research and interviews performed during the development of this plan, three primary focus areas have emerged: *Structure, Awareness, and Intervention.* Itemized on the following pages are the goals, objectives, and strategies that collectively address and support each of these focus areas.

FOCUS AREA 1: STRUCTURE

GOAL I: Mississippi will Address the Issue of Youth Suicide through a Structured and Sustainable Means.

Objective A: Establish a lead entity to assume responsibility for the development of a comprehensive and coordinated system of information and intervention efforts for the prevention of youth suicide.

Strategy 1**:** Define the purpose, structure and governance of the entity

Strategy 2**:** Identify and recruit key, diverse members

Strategy 3: Develop and adopt bylaws

Strategy 4: Elect/appoint officers

Strategy 5: Establish action plan to guide efforts

Objective B: Maintain established entity to lead and coordinate ongoing youth suicide prevention Efforts.

Strategy 1: Identify & seek appropriate funding opportunities to sustain youth suicide prevention efforts.

Strategy 2: Develop a system for ongoing evaluation for informational and intervention efforts.

Strategy 3: Conduct and/or contract for relevant research and studies

Strategy 4: Coordinate/integrate efforts with any other ongoing programs, services, and information.

Strategy 5: Identify and promote expanded surveillance that captures relevant information/data regarding youth suicides in the state.

FOCUS AREA 2: **AWARENESS**

GOAL II: Awareness Of and About Youth Suicide and Its Prevention will be Significantly Increased.

Objective A: Develop a statewide public information and education campaign, that, among other things, reduces the stigma of and sensitivity to suicide.

Resources would include (1) Jason Foundation school-based curriculum for youth, parent seminars, and staff development seminars; and (2) Youth Suicide Prevention Program's state-wide public education and community action toolkit and media relations reporting guidelines.

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Strategy 1: Determine message, focus, and means of information dissemination

Strategy 2: Use public media (tv, radio, billboards, newspaper)

Strategy 3: Developed and disseminate materials (brochures, flyers, videos)

Strategy 4: Initiate an active website

Strategy 5: Conduct presentations at clubs, conferences, trainings, etc.

Strategy 6: Integrate suicide prevention message with other public information campaigns (substance abuse depression, violence prevention, gun safety)

Strategy 7: Develop and incorporate strategies to reduce the stigma associated with being a consumer of mental health services.

Strategy 8: Seek funding for implementation of the marketing plan.

Strategy 9: Train and partner effectively with the media

Strategy 10: Disseminate information about suicide prevention hotlines that are available (Lifeline 1-800-273-TALK, 1-800-SUICIDE, etc)

Objective B: Develop a suicide prevention clearinghouse, including current and relevant statistics, lending library, practice guidelines, success stories, "promising preventive methods and technologies", and speakers' bureau

Strategy 1: Collect and organize appropriate and necessary materials, information, etc.

Strategy 2: Establish process for access to materials/ information by youth, professional, parents and community members

Strategy 3: Recruit and train presenters

Strategy 4: Update and maintain website

Objective C: Evaluate public awareness campaign by measuring increase in knowledge, skills, and attitude of public, parents, youth, and professional staff.

Strategy 1: Develop pre and post evaluation tool to measure desired awareness outcomes.

Strategy 2: Identify evaluation participants

Strategy 3: Administer evaluation tool prior to and after campaign.

Strategy 4: Report findings

FOCUS AREA 3: INTERVENTION

GOAL III: Appropriate and Effective Youth Suicide Prevention Strategies will be Developed, Implemented, and Evaluated.

Objective A: Implement "gatekeeper" professional training for the assessment, treatment, and management of suicidal youth, including:

- "SOS" (signs of suicide),
- A.S.I.S.T.(18-24)(train-the-trainer model),
- Jason Foundation,
- Trauma-focused Cognitive Behavioral Therapy (Catholic Charities),
- Youth Suicide Prevention Program's "gatekeeper" training curriculum.

Gatekeepers" are those professionals in the community who have the opportunity to detect the conditions that lead to suicide and assist in obtaining help, i.e., school personnel; mental health, healthcare, social service, and juvenile justice professionals; and clergy.

Strategy 1: Promote "gatekeeper" professional **school** Curriculum to include/improve/enhance the recognition and treatment of suicidal behavior in youth.

Strategy 2: Encourage gatekeeper professional certification programs to

include **continuing education** on youth suicide issues and prevention.

Strategy 3: Make available youth suicide prevention training and education opportunities through conferences, seminars, workshops, and electronic venues for (a) mental health, (b) social service, (c) juvenile justice, and (d) health care professionals, and (e) clergy and other youth ministry personnel.

Strategy 4: Utilize therapists at all 16 CMHCs to intervene and treat referred youth using the “learning collaborative approach”.

Strategy 5: Identify training opportunities for clinical professionals

Strategy 6: Identify screening tools and strategies for assessing and managing suicide risk

Objective B: Enhance/promote effective clinical and professional practices

Strategy 1: Endorse and recommend and/or develop appropriate screening tools to assess depression, anxiety, stress, aggression, coping and problem solving skills, history of trauma/abuse, substance abuse, and other socio-cultural and environmental stressors.

Strategy 2: Promote better access to and use of informal mental health screening and support better linkages with and access to mental health services.

Strategy 3: Develop “best practices” guidelines; policies, procedures, and aftercare protocols.

Strategy 4: Develop and provide education for families of youth receiving care for psychiatric disorders, physical/sexual abuse, previous attempted suicide, excessive use of antidepressants, recent intense crisis (loss of loved one) or social “fitting” issues (gay/lesbian, bullied)

Strategy 5: Foster and promote continuity of care among consumers, treatment, education, and service sectors; and help overcome barriers to information sharing and collaboration.

Objective C: Promote and help develop youth/young adult suicide prevention programs throughout the state.

Strategy 1: Design (use/modify existing) and facilitate the implementation of:

a. Evidence-based projects/activities in public and private schools

designed to address serious adolescent stressors that may lead to youth suicide;

b. Evidence-based projects/activities in colleges designed to address serious young adult stressors that may lead to suicide;

c. Evidence-based suicide prevention projects/ activities in youth courts/detention centers;

d. Evidence-based projects/activities for youth/family service providers that identify and address serious stressors that may lead to youth suicide;

e. Evidence-based projects/activities for mental health providers that identify and address serious stressors and risk factors that may lead to youth suicide.

Strategy 2: Develop a high school and/or college anonymous, interactive, web-based screening tool that identifies those most at-risk for suicide and encourages to get treatment based on one developed by American Foundation for Suicide Prevention and piloted at Emory and University of North Carolina.

Objective D: Reduce access by youth to lethal methods of self-harm

Strategy 1: Develop as part of the public information campaign a component directed at families that is designed to reduce accessibility to lethal means, (guns, prescription drugs, etc.)

Objective E: Evaluate intervention methodologies through observable evidence and/or assessment tools, surveys, and interviews.

Strategy 1: Measure "gatekeeper" knowledge, skill, and attitude before and after training;

Strategy 2: Measure the development, use, and outcome of screening tools;

Strategy 3: Identify "best practices" development and utilization by professionals;

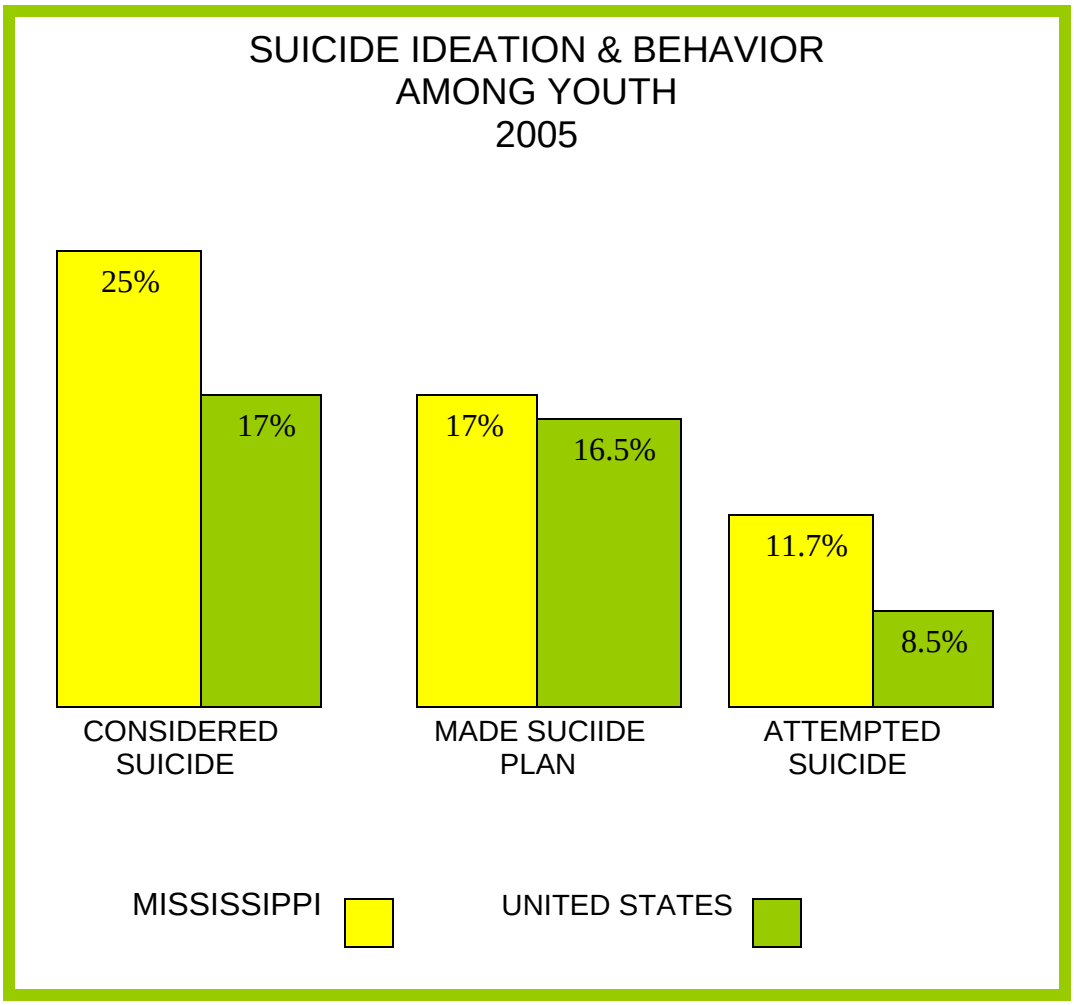
Strategy 4: Identify the development and use of specialized education for family members with high-risk youth incorporated into mental health practice;

Strategy 5: Identify the development, implementation, and utilization of suicide prevention projects and activities in the various disciplines;

(The outcome, or results, of the individually- developed projects/ activities will be an organizational/discipline- specific responsibility. This proposed plan would cover the review and dissemination of the outcomes however.)

LOGIC MODEL
MISSISSIPPI YOUTH SUICIDE PREVETION PLAN

RESOURCES	INPUTS	OUTPUTS	OUTCOMES	GOALS
School & Community "gatekeepers" Youth Parents Mental Health & Health Providers Jason Foundation National resources YSP Advisory Bd. SP materials, website & other information Training providers Marketing tools/resources Funding	Marketing Campaign planning Mkt. Campaign implementation Collect, organize, and disseminate SP materials, website, speakers, and other inf Capacity Building Activities *(training, education, TA, tool development, clinical practice, etc.)* Collaboration among consumer, treatment, education, and service sectors Development of evidence-based school, family, and community SP projects/activities	Create campaign and media materials Utilization of materials Presentations made school & community settings Youth /community members exposed to SP message Youth, gatekeepers, & families educated and trained, become more knowledgeable and better prepared Improved practices and continuity of care Website established	**Individual level** - Increased awareness of YSP - Increased knowledge of YSP - Increased willingness to help youth - Acquisition of helping behaviors **School Level** -Enhanced involvement by staff, teachers, parents and youth - Increased awareness and acknowledgment of youth suicide - More informed supportive atmosphere - Adoption of new policies / procedures addressing youth suicide **Community Level** - Enhanced awareness of youth suicide issue and prevention efforts - Community members more knowledgeable and better prepared - Increased involvement in prevention efforts - Stigma reduced - Access to lethal means reduced -	Reduce youth suicide behavior Reduce youth suicide attempts Reduce number of deaths from youth suicide


SUICIDE IDEATION & BEHAVIOR
AMONG YOUTH
2005
25%
17%
17%
16.5%
11.7%
8.5%
CONSIDERED SUICIDE
MADE SUCIIDE PLAN
ATTEMPTED SUICIDE
MISSISSIPPI
UNITED STATES

MISSISSIPPI YOUTH SUICIDE PREVENTION PLAN
YEAR 1
(July1, 2007 – June 30, 2008)

Strategies **Outcome**	**Action Taken**
1. Define purpose, function, and governance of the lead entity to address suicide prevention	
a. Identify and recruit members	
b. Develop and adopt bylaws	
c. Elect/appoint officers	
d. Establish action plan to guide efforts	
2. Conduct research to identify evidence-based projects and activities for schools, colleges, youth courts, CMH centers, healthcare facilities, and families.	
a. Plan evidence-based projects/activities	
b. Begin developing projects/activities	
c. Coordinate/integrate efforts with other programs	
3. Determine marketing plan: message (prevalence, indicators, stigma, access to lethal means, etc.); audience(s); and identify most effective means to disseminate information	
a. Integrate message with other public info. campaigns as appropriate	
b. Begin collecting materials and other suicide prevention information and resources	
c. Implement non-expense items of mkt plan (presentations/seminars, existing materials, resources, curriculum, toolkits, and PSAs)	

Strategies **Outcome**	**Action Taken**
d. Identify and seek funding for market campaign	
4. Promote and begin facilitating "gatekeeper" training and effective clinical/professional practice opportunities	

a. Utilize Jason Fnd., YSPP, S.O.S., A.S.I.S.T., trauma-focused cognitive behavioral therapy resources, and others.
b. Initiate the "learning collaborative approach" with therapists at all CMHCs in the state to intervene and treat referred youth.
c. Identify and recommend appropriate screening tools to better assess psychological, socio-cultural, and environmental stressors that may trigger a suicide attempt.
5. Identify and develop evaluation criteria and methodology

Appendix B

Letter from the Chairperson of the Mississisippi State Mental Health Planning and Advisory Council

Appendix C

Letters of Support and Interagency Coordinating Council for Children and Youth (ICCCY) Memoranda of Understanding

Mississippi Department of Education
Tom Burnham, Ed.D. • State Superintendent of Education

Lynn J. House, Ph.D. • Deputy State Superintendent • Office of Instructional Enhancement and Internal Operations

Office of Special Education
Ann Moore • Associate State Superintendent • 601-359-3498 • FAX: 601-359-2198

August 18, 2011

Edwin C. LeGrand III, Executive Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

Dear Mr. LeGrand:

On behalf of the Mississippi Department of Education, I would like to offer our support for the Mississippi Department of Mental Health (MDMH) in their submission of the FY 2012-2013 Block Grant application for Community Mental Health Services for children and youth with serious emotional disturbance and adults with serious mental illness.

The Department of Education has been strongly involved with the Department of Mental Health. The State Superintendent of Education supports the Interagency Coordinating Council for Children and Youth. In addition, the Department of Education has been represented on the Mississippi Mental Health Planning and Advisory Council, and representatives of the Department also participate on the Interagency System of Care Council and the State Level Case Review Team and Making a Plan teams.

The Department values its partnership with the Department of Health and will continue to offer its support to MDMH in its efforts to deliver quality mental health services to the children, youth and families of Mississippi.

Sincerely,

Ann Moore
Associate State Superintendent

Central High School Building • 359 North West Street • P. O. Box 771 • Jackson, MS 39205-0771

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

August 11, 2011

Edwin C. LeGrand III, Executive Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

Dear Mr. LeGrand,

The Division of Medicaid supports the Mississippi Department of Mental Health in their submission of the FY 2012-2013 Block Grant application for Community Mental Health Services for children and youth with serious emotional disturbance and adults with serious mental illness.

The Division of Medicaid is represented on the Mississippi Mental Health Planning and Advisory Council by Ms. Bonlitha Windham. Ms. Windham serves as the agency liaison to the Department of Mental Health, attends Planning Council Meetings, and provides information concerning our agency's activities as requested. Ms. Windham also submitted information to the Department of Mental Health to be included in the Block Grant application concerning the Division of Medicaid's role and collaboration with the Department of Mental Health in the delivery of behavioral health services.

Representatives from the Department of Mental Health, Bureau of Community Services meet quarterly with staff at the Division of Medicaid concerning the benefits available to the Medicaid population. The Division of Medicaid and the Department of Mental Health continue to work together to ensure appropriate services are provided to its beneficiaries.

The Division of Medicaid values the partnership that exists between our agency and the Department of Mental Health and will continue to work with you in the delivery of services to Mississippians with mental illness.

Sincerely,

Robert L. Robinson

RLR/gs

550 HIGH STREET, SUITE 1000, JACKSON, MS 39201, (601) 359-6050.

STATE OF MISSISSIPPI
HALEY REEVES BARBOUR, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
DON THOMPSON
EXECUTIVE DIRECTOR

August 15, 2011

Mr. Edwin C. LeGrand III, Executive Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

Dear Mr. LeGrand:

The Mississippi Department of Human Services supports the Mississippi Department of Mental Health in their submission of the FY 2012-2013 Block Grant application for Community Mental Health Services for children and youth with serious emotional disturbance and adults with serious mental illness.

The Department of Mental Health and the Department of Human Services work collaboratively in several areas concerning the welfare of children, youth, and their families including therapeutic foster care, juvenile justice, the State Level Case Review Team, and statewide Making A Plan (MAP) Teams. The Department of Human Services has representatives on the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC) that serve with representatives from the Department of Mental Health and other State agencies to maintain interagency collaboration and coordination among agencies serving children, youth, and their families.

The Mississippi Department of Human Services is represented on the Mississippi Mental Health Planning and Advisory Council by Ms. Sandra McClendon. Ms. McClendon participates on the Children's Services Task Force and serves as the agency liaison to the Department of Mental Health. She attends Planning Council Meetings and provides information concerning our agency's activities as requested. Ms. McClendon submitted information to the Department of Mental Health to be included in the Block Grant application concerning the Mississippi Department of Human Services' role and collaboration with the Department of Mental Health in the delivery of behavioral health services.

The Department of Human Services supports the Department of Mental Health in their effort to provide behavioral health services to the children, youth, and families in our State with mental illness and agree with the role of our agency described in the application.

Sincerely,

Lori Woodruff

Lori Woodruff, Deputy Administrator
Division of Family and Children's Services

LW:bh

P.O. BOX 352 • JACKSON, MISSISSIPPI 39205 • TELEPHONE (601) 359-4690 • www.mdhs.state.ms.us

MISSISSIPPI STATE DEPARTMENT OF HEALTH

August 19, 2011

Edwin C. LeGrand III, Executive Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

Dear Mr. LeGrand:

The Mississippi Department of Health supports the Mississippi Department of Mental Health in their submission of the FY 2012-2013 Block Grant application for Community Mental Health Services for children and youth with serious emotional disturbance and adults with serious mental illness.

The Mississippi Department of Health is represented on the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC) that serve with representatives from the Department of Mental Health and other State agencies to maintain interagency collaboration and coordination among agencies serving children, youth, and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities and collaborates with the Department of Mental Health in specified areas of the state to provide these services.

Ms. Geneva Cannon represents the Department of Health on the Children's Services Task Force, a subcommittee of the Mississippi Mental Health Planning and Advisory Council, and provides information on initiatives and activities within the Department of Health. Staff at the Department of Health submitted information to the Department of Mental Health to be included in the Block Grant application concerning our agency's role and collaboration with the Department of Mental Health in the delivery of behavioral health services.

The Mississippi Department of Health looks forward to continued collaboration and partnership with the Department of Mental Health and supports their submission of the FY 2012-2013 Block Grant application.

Sincerely,

Mary Currier, MD, MPH
State Health Officer

570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
1-866-HLTHY4U • www.HealthyMS.com

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Mississippi Department of Rehabilitation Services

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August 25, 2011

Edwin C. LeGrand III, Executive Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

Dear Mr. LeGrand:

The Mississippi Department of Rehabilitation Services (MDRS) supports the Mississippi Department of Mental Health in their submission of the FY 2012-2013 Block Grant application for Community Mental Health Services for children and youth with serious emotional disturbance and adults with serious mental illness.

The Mississippi Department of Rehabilitation Services is represented on the Mississippi Mental Health Planning and Advisory Council by Mr. Lee Alderman. Mr. Alderman is new to the Council and is replacing Ms. Patty Horton. Mr. Alderman will serve as the agency liaison to the Department of Mental Health and provide information concerning our agency's activities.

A representative of the Mississippi Department of Rehabilitation Services attends the State-Level Interagency Case Review Team and Making a Plan (MAP) Team meetings for youth at risk for out of home or out of state placement. A representative of the Office of Vocational Rehabilitation Services within the MDRS attends the Transitional Services Task Force meetings and provides members with information on meeting the employment needs of youth in the transitional age range. The Department of Rehabilitation Services is represented on the state executive-level Interagency Coordinating Council for Children and Youth (ICCCY) and participates on the mid-management state level Interagency System of Care Council (ISCC).

General vocational rehabilitation services are available to individuals with serious mental illness through referral to the Office of Vocational Rehabilitation in the Mississippi Department of Rehabilitation Services. Additionally, a representative from the Office of Vocational Rehabilitation also participates on the Transportation Coalition.

The Mississippi Department of Rehabilitation Services values the relationship that exists between our agency and the Department of Mental Health. We support them in their effort to deliver quality mental health services to the children, youth, families and individuals in Mississippi with mental illness.

Sincerely,

H.S. McMillan
Executive Director

1281 Highway 51 • Madison, MS 39110 • Post Office Box 1698 • Jackson, MS 39215-1698 • Telephone: (601) 853-5100 Voice or TDD