

FY 2011 MISSISSIPPI STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES

FOREWORD

The Fiscal Year 2011 Mississippi State Plan for Community Mental Health Services was developed by staff of the Mississippi Department of Mental Health, in collaboration with the Mississippi State Mental Health Planning and Advisory Council. The Council serves in an advisory capacity to the Department in identifying service needs, in updating annual objectives to meet those needs, and in reviewing and monitoring progress on implementation of objectives throughout the year. The Mississippi Department of Mental Health greatly appreciates the commitment and work of Council members, and primary consumers from across the state. Their contributions to the ongoing planning process are key to continued progress in improving availability and accessibility of services for adults with serious mental illness and children with serious emotional disturbance. This State Plan document represents the cumulative long-range planning efforts of the Council and the Department of Mental Health in setting forth and pursuing a vision for an ideal comprehensive system of community mental health services for children with serious emotional disturbance and adults with serious mental illness in Mississippi. The Plan also addresses criteria for state plans included in federal law, as required in the state's application for Center for Mental Health Services Block Grant funds.

The purpose of the State Plan for Community Mental Health Services is to describe the comprehensive, community-based service delivery system for individuals with mental illness upon which program planning and development are based, to set forth annual goals/objectives to address identified needs, to assist the public in understanding efforts employed and planned by the Department of Mental Health to provide supports to Mississippi's citizens with mental illness and serious emotional disturbance, to serve as a basis for utilization of federal, state and other available resources, and to provide, through the Mississippi State Planning and Advisory Council, an avenue for individuals, family members, and service providers to work together in identifying and planning an array of services and supports through the annual update of this Plan.

A Note About Funding: The FY 2011 State Plan includes objectives related to state funds, as well as use of other resources for community mental health services. Included under Criterion #5 in the Children's Plan and under Criterion #5 in the Adult Plan are objectives to request additional state funds for the 2012 fiscal year. Changes indicated under these criteria also reflect projected use of CMHS Block Grant funds in FY 2011, including the increase in FY 2010 (current year) CMHS Block Grant funds. Because of budget reductions in FY 2010 and FY 2011, additional modifications to objectives may be required.

Because the State Plan is considered a working document, the public is encouraged to submit comments to:

The Mississippi State Mental Health Planning and Advisory Council
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Mississippi Department of Mental Health
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Comments to the Draft FY 2011 State Plan received after the comment period (July 12 – August 10, 2010) will be considered in development of the FY 2012 Plan.

Mississippi State Mental Health Planning and Advisory Council Members – 2010

Myrna Douglas, Chairperson (to June 29, 2010)
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6/30/10 (retired); replacement appointment
pending]
Sheila McGraw
Shane McNeill
Kristen Owen
Elaine Owens (new member, 7/10)
Greg Patin
Kristi Plotner
Linda Raff
Kim Richardson
Bradley Sanders
Charlie Spearman, Sr.
Karla Steckler (for DHS through 6/30/10;
replaced by:
Sandra McClendon (new DHS rep., 7/10)
Larry Waller
Debra Wertz

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SECTION I. Description of the State Service System

General Description of the State Population - According to 2000 U. S. Census figures, Mississippi has a population of 2,844,658. The state has a significant minority population, with an estimated 39% of its citizens identified as nonwhite. Of the total number of nonwhite individuals, approximately 94% are African-American. The majority of Mississippians (approximately 61%) are between the ages of 18 and 64. Twenty-seven percent of the population are below 18 years of age, and approximately 12% are 65 years of age or older. In 2000, 48% of the population was male and 52% was female.

The 1990 U. S. Census indicated that in 1989, 20.2% of Mississippi families lived below the poverty level. According to the 2000 U.S. Census, in 1999, 19.9% of individuals in Mississippi lived below the poverty level, and 16% of Mississippi families lived below the poverty level. The 2000 Census also indicated that 22.2% of families with related children under 18 years of age lived below the poverty level in 1999. Over the last decade, Mississippi has shown increases in income and signs of decreasing unemployment. The per capita income of Mississippi in 1991 was reported to be \$13,328, which was 69.8% of the national average (*Handbook of Selected Data, 1993*); however, based on the 2000 U.S. Census, per capita income had risen to \$15,853. In 1991, unemployment was 8.6% (*Handbook of Selected Data, 1993*). The moving 12-month average unemployment rate for the state as of April 2010 was 10.4%, with the number of unemployed averaging 135,200 and the number of employed (excluding the military) averaging 1,158,800. (The national average unemployment rate for the month of April 2010 was 9.7%. Mississippi Department of Employment Security, May 2009).

A rural state, only 14% of Mississippi's 47,233 square miles is urbanized. The areas of the state where its population are concentrated are in the west central area of the state (the Jackson metropolitan area) and on the Gulf Coast. Of its 82 counties, 21 are designated as 100% rural, based on rural and urban designations resulting from 2000 U.S. Census data.

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, the Office of Constituency Services, the Director of Public Information, and the Director of Disaster Preparedness and Response report directly to the Executive Director. The Division of Disaster Preparedness and Response is responsible for the development of a disaster behavioral health response system and the development and maintenance of the DMH's Statewide Disaster Response Plan. Additionally, this division is responsible for carrying out the responsibilities as assigned to the MS Department of Mental Health in Mississippi's Comprehensive Emergency Management Plan. In the event of a disaster declared by the President, the Division of Disaster Preparedness and Response is responsible for the establishment and oversight of the FEMA funded crisis counseling program in the affected areas. Should additional assistance be needed, the Division of Disaster Preparedness and Response has the capacity to activate 18 additional disaster behavioral health team members to assist with response. Recognizing the traumatic effects disasters have on individuals and communities, the Division of Disaster Preparedness and Response has partnered with two National Child Traumatic Stress Network sites in Mississippi to promote the provision of trauma-informed care in the public mental health system. Specifically, the Division has participated in planning and implementation of the Trauma-Focused Cognitive Behavioral Therapy Learning Collaboratives, the first Psychological First Aid Learning Community, and the Psychological First Aid Trainer Track of the Learning Community.

DMH has seven bureaus: Administration, the Mental Health, Community Mental Health Services, Alcohol and Drug Abuse Services, Intellectual and Developmental Disabilities, the Interdisciplinary Programs, 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: Accreditation and Licensure, 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. For example, the Division oversees the provision of pre-evaluation screening training and is working to address the development of a strategic plan for housing. The Division of Accreditation and Licensure for Mental Health is responsible for coordination and development of minimum standards for community programs that receive funds through the authority of the Department of Mental Health, as well as the coordination of review, monitoring, and certification processes to ensure that all community programs meet those minimum standards. The Division works with staff of other service divisions in the Central Office to implement this ongoing program monitoring process. Objectives of other service divisions are described in the text of the State Plans.

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 includes

the Division of Home and Community-Based (HCBS) ID/DD Waiver and the Division of Early Intervention Services.

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 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.

The Division of Constituency Services is responsible for the 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.

The Division of Disaster Preparedness and Response, which carries out MDMH's responsibilities as outlined in the *Mississippi Comprehensive Emergency Management Plan*, refines DMH's statewide disaster response system and creates and maintains the agency's disaster response plan. This division assists the DMH-operated facilities and local community mental health centers with disaster preparedness and response efforts.

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 minimum standards for the operation of those services it funds, and to monitor compliance with those minimum 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. As described throughout the State Plan, 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 (described in the State Plan).

State Certification and Program Monitoring The Mississippi Department of Mental Health ensures implementation of minimum 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 minimum 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 minimum 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 Accreditation and Licensure. 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 2011 State Plan includes objectives related to state funds that were appropriated for specific purposes by the State Legislature in 2010. Also included under Criterion 5 in the FY 2011 State Plan are objectives to request additional state funds for the 2012 fiscal year. Criterion 5 also reflects projected use of federal Community Mental Health Services (CMHS) Block Grant funds in FY 2011, including an increase in FY 2010 (current year) CMHS Block Grant funds. The DMH administers and grants to local providers funding from the federal CMHS block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as the PATH program). The DMH also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH

subsequently administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) The DMH also 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. Due to the budget reductions in FY 2010 and the potential for further budget cuts in FY 2011, modification to objectives may be required to this plan.

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.

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

As mentioned above, 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 (described previously); 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. (See section that follows on how the State mental health agency provides leadership in coordinating mental health services within the broader system.)

Summary of Areas Previously Identified by State as Needing Attention

Areas on which Attention was focused in FY 2010 for Services for Children with Serious Emotional Disturbance

- Continued funding, monitoring of implementation and training of local MAP teams as well as plans for expansion to those counties with no access to a MAP Team.
- Continued collaboration with the Department of Human Services (DHS), Division of Youth Services in the implementation of Adolescent "A" Teams for those youth with SED who are involved in the juvenile justice system. Additionally, Division staff continued collaboration with DHS in the training, development, and implementation of Adolescent Offender Programs (AOPs) in

those counties that do not already operate an AOP.

- Continued training of local service providers and cross agency training on mental health issues in youth, system of care development, strengths-based assessment, a wrap around approach to services, and trauma-focused cognitive behavior therapy, with focus on implementation of these concepts in the field.
- Continued work by the members of the Interagency System of Care Council on the evaluation of policies and procedures and facilitating cross-training opportunities across agencies serving youth and families.
- Increased work on the implementation of the Fetal Alcohol Spectrum Disorder (FASD) project and training on the identification, screening, and assessment of those youth, ages birth -7 years of age, who are at-risk or may exhibit symptoms of FASD. Continued implementation of the FASD state plan and quarterly meetings of the state FASD Advisory Council.
- Continued collaboration across the Division of Children and Youth Services, the Bureau of Alcohol and Drug Abuse, and the Division of Community Services for Adults to identify and disseminate best practices and other program improvements addressing youth in need of services for alcohol and/or drug use.
- Continued collaboration with the educational system through MAP Teams, the Interagency System of Care Council, and the State Level Case Review Team. Continued training, technical assistance, and certification of school-based programs offered by local community mental health centers.
- Continued funding and support for two Transitional Outreach Programs that serve youth/young adults, between 16-21 years of age.
- Continue funding and support for five comprehensive crisis intervention programs, as well as five smaller, specialized crisis intervention projects.

Areas on which Attention was focused in FY 2010 for Services for Adults with Serious Mental Illness

- In FY 2009 the Mississippi Legislature approved the Department of Mental Health Crisis Center Redesign Plan, permitting DMH to pilot the transition of operation of the state-operated crisis center in Grenada to operation as a crisis stabilization unit by Life Help Community Mental Health Center. In FY 2010 DMH sought and received legislative approval to transition the remaining six state-operated crisis centers from operation by the state hospitals to operation by regional community mental health centers. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of

the remaining six units. The operation of all seven crisis stabilization units will be based on the redesign piloted in Grenada, which includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services.

- Improving the quality of clubhouse psychosocial rehabilitation services throughout all service regions of the state and expanding the number of ICCD certified clubhouses to a minimum of one in each community mental health region in the state.
- Improving the quality and facilitating further development of psychosocial rehabilitation services for persons who are elderly throughout all service regions in the state, including community-based services and services for individuals in nursing homes.
- Creating and maintaining a more person-directed service system for individuals with serious mental illness by incorporating person-centered philosophy throughout Department of Mental Health. As directed by its governing Board, DMH has been working diligently on an agency-wide Strategic Plan that addresses all areas of service responsibility. A major theme of the plan is to achieve a more person-directed service system, which will be reflected in the DMH standards review and revision process.
- Continuing efforts to support and improve specialized programs for persons with mental illness who are homeless. DMH also applied for and received SOAR technical assistance to work with individuals who are homeless and have mental illness.
- Continuing initiatives to improve evidence-based services by providing training to address the full integration of services for individuals with co-occurring disorders of mental illness and substance abuse disorders. In 2010, DMH received federal Transformation Transfer Initiative funding that will facilitate training on effective assessment and treatment in community mental health regions and state hospitals that have not received the training in the previous year.
- DMH is in the final stages of revising its *Minimum Standards for Community Mental Health Services*. Once approved, DMH will begin training service providers on the revised standards and monitoring of programs will begin in the next calendar year.
- Increasing coordination of transportation services to address the needs and barriers experienced by individuals served in the public community mental health system and exploring funding opportunities to support piloting of initiatives developed by the Mississippi Coordinated Transportation Coalition. DMH received a TTI grant that will enhance the coordination of transportation

services and service providers. DMH will also use grant funds to pay for transportation for individuals with disabilities.

- Establishment of a Housing Task Force and initiation of a statewide strategic planning project to develop additional housing options for persons with serious mental illness.
- Continue working with the Division of Medicaid to develop a proposed State Plan Amendment and/or waiver for submission to the Centers for Medicare and Medicaid Services that, if approved, would facilitate changes in community-based services to further support resilience/recovery.
- Continue collaboration with the University of Mississippi Medical Center's Department of Psychiatry and Human Behavior, which is implementing telehealth pilot programs in the Delta region of the state.

New Developments and Issues

Mississippi Youth Programs Around the Clock (MYPAC)

The Mississippi Division of Medicaid began implementation of MYPAC in October 1, 2007. MYPAC is a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) for a 1915 (c) home and community-based waiver program for youth with serious emotional disturbances. MYPAC provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) for youth still needing the same level of care. Services include Intensive Case Management, Wraparound Services, and Respite Services which are implemented by one of the two providers, Youth Villages or Mississippi Children's Home Society.

The Department of Mental Health, in collaboration with the MS Division of Medicaid, completed a Real Choice Systems Change project, funded by the Centers for Medicare and Medicaid Services (CMS) to pilot a person-directed planning process. Targeted in the project were individuals most at risk for hospitalization or rehospitalization, such as individuals with co-occurring mental illness and substance abuse disorders, as well as adolescents and young adults in transition from child to adult service systems. Inherent in implementation of the person-centered planning process is a shift in philosophy to more individualized, person-driven services. The Department of Mental Health collaborated with the MS Division of Medicaid to implement a Rebalancing Initiative funded by CMS to address transportation planning; CMS funding for the project ended in September 2008. The goal of this project was to coordinate statewide planning for transportation services for individuals with disabilities by working with state and local transportation services providers to offer an array of transportation services. The Mississippi Coordinated Transportation Workgroup continued to meet in FY 2010 to explore funding opportunities and needs for legislation to pilot efforts developed during the planning grant period.

Legislative Initiatives and Changes

The Department of Mental Health continues to address the following legislative initiatives:

The Mental Health Reform Act of 1997, often referred to as Senate Bill, 2100, was passed during the 1997 Session of the Mississippi Legislature and continues to impact the public community mental health system. This significant piece of legislation resulted from several months of study of mental health services in the state by a special subcommittee of the Mississippi Senate Appropriations Committee and was supported by major mental health advocacy groups and the MS Department of Mental Health. Some major areas addressed by the Mental Health Reform Act include: further codification of the Department of Mental Health's authority to set and enforce minimum standards for community mental health services and to ensure uniformity in availability and quality of basic services for adults and children across the 15 mental health regions in the state; establishment of crisis centers; and, further development in the administration and provision of care to improve the quality of community mental health services. The Department of Mental Health has continued processes for implementation of the provisions of the Mental Health Reform Act of 1997 as resources have become available, including family members, consumers, and service providers in review of policies and procedures related to these efforts. The establishment of the DMH Office of Constituency Services, construction of a network of state-operated crisis centers, and implementation of comprehensive revisions to the *MS Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services*, which are described in Section III that follows, are all initiatives undertaken to implement provisions in the Mental Health Reform Act.

House Bill 512, effective July 1, 2010, requires that an individual have a prescription in order to purchase ephedrine and pseudoephedrine; this legislation is a part of efforts to address the problem of methamphetamine in the state.

House Bill 664, effective July 1, 2010, creates the Mississippi Silver Alert System Act of 2010, which will help to alert the public when an individual with dementia or other cognitive impairments is missing.

House Bill 929, which was passed in 2000, set forth in statute the purpose, process, membership and product of the statewide Mississippi Access to Care (MAC) workgroup. The legislation called for a statewide work group to develop a proposed plan for presentation to the Legislature by September 30, 2001. As noted, the Department of Mental Health continues to address recommendations in the MAC Plan as resources are available.

House Bill 965, passed during the 2010 regular session, amended portions of the DMH's FY 2010 appropriations bill that allow for implementation of the Crisis Center Redesign plan (described in more detail under Criterion 1).

House Bill 1049, effective July 1, 2010, provides the framework needed for the establishment of Crisis Intervention Teams (CIT) by local jurisdictions statewide; no additional appropriations specifically for that purpose were authorized by the bill.

House Bill 1529, passed during the 2010 Regular Session, continued the authorization of the Interagency Coordinating Council for Children and Youth (ICCCY) with the following revisions: expanded ICCCY to include the Attorney General, an additional family member, a youth or young adult, a local MAP Team Coordinator, a child psychiatrist, an early childhood education representative, an advocate for individuals with disabilities, and a faculty member or dean from a Mississippi university; increased decision-making authority for those representatives; provided for incorporation of local MAP Team representation through policies and/or regulations; revised the Interagency Agreement; and, continued development of local MAP Teams across the state.

House Bill 1479, passed during the 2010 Regular Session, changes the name of Oakley Training School to the Oakley Youth Development Center. This legislation also revised the admission/commitment criteria for Oakley Youth Development Center to include youth who have been adjudicated delinquent for a felony or who have been adjudicated delinquent three or more times for a misdemeanor offense.

Senate Bill 2645, passed during the 2010 Regular Session, authorizes the continuation of the Mental Health Study Committee for another year with a report deadline by January 2011. The conference report recommends a closer examination of the CMHC system and includes a provision to pay the expenses of the legislators on the study committee.

Senate Bill 2770, which passed during the 2009 Regular Session of the Mississippi Legislature, calls for the Mississippi Department of Education to require local school districts to conduct inservice training on suicide prevention for all licensed teachers and principals, to begin in the 2009-2010 school year. Beginning in the 2010-2011 school year, the Mississippi Department of Education is mandated to require local school districts to conduct inservice training on suicide prevention for all newly licensed teachers and principals. The Mississippi Department of Mental Health is responsible for development of the content of the training and determining the appropriate amount of time that should be allotted for the training.

House Bill 897, which passed during the 2009 Regular Session, which calls for the establishment of a Joint Legislative Study Committee and allows for the formation of an advisory council to that study committee. The committee is charged with studying and making recommendations for improving the mental health system and with making recommendations to the Legislature, including any recommended legislation, by December 1, 2009.

Senate Bill 2016, which passed during the 2009 Regular Session, which calls for the State Board of Mental Health to establish minimum standards and certify county facilities used for housing persons who have been involuntarily committed pending transportation and admission to a state treatment facility.

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 $\frac{3}{4}$ mill tax in 1982 or (2) the actual contribution made in 1984.

All counties were in compliance with this provision for 2009; 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, DeSoto , * Lafayette, Marshall, Panola, Tate, Yalobusha *Change effective October 1, 2010	Communicare Carole B. Haney, Acting 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* *Change effective October 1, 2010	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

<p>Region 8: Copiah, Madison, Rankin, Simpson, Lincoln* *Change effective October 1, 2010</p>	<p>Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)</p>
<p>Region 9: Hinds</p>	<p>Hinds Behavioral Health Margaret L. Harris, Director P.O. Box 777, 3450 Highway 80 West Jackson, MS 39284 (601) 321-2400</p>
<p>Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith</p>	<p>Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 4378 Meridian, MS 39304 (601) 483-4821</p>
<p>Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln*, Pike, Walthall, Wilkinson *Change effective October 1, 2010</p>	<p>Southwest MS Mental Health Complex Steve Ellis, Ph.D., Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173</p>
<p>Region 12: Covington, Forrest, Greene, Jeff Davis, Jones, Lamar, Marion, Perry, Wayne</p>	<p>Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 1030 Hattiesburg, MS 39403 (601) 544-4641</p>
<p>Region 13: Hancock, Harrison, Pearl River, Stone</p>	<p>Gulf Coast Mental Health Center Jeffrey L. Bennett, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132</p>
<p>Region 14: George, Jackson</p>	<p>Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690</p>
<p>Region 15: Warren, Yazoo</p>	<p>Warren-Yazoo Mental Health Services Steve Roark, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031</p>

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, Specialized Treatment Facility, and Central Mississippi Residential Center. 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.

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.

Available Services and Supports

Both community-based and facility supports are available through the DMH service system. The type of services offered depends on the location, provider and needs of the individuals.

Community Services

A variety of community services and supports, as listed below, are available. Services are provided to adults with mental illness, children and youth with serious emotional disturbance, children and adults with intellectual/developmental disabilities, people with substance abuse problems, and persons with Alzheimer's disease or other dementia.

Services for Adults with Mental Illness

Crisis Stabilization Programs
Psychosocial Rehabilitation
Consultation and Education Crisis/Emergency Mental Health Services
Inpatient Referral Services
Pre-Evaluation Screening/Civil Commitment Exams
Outpatient Therapy
Case Management Services
Halfway House Services
Group Home Services
Acute Partial Hospitalization
Elderly Psychosocial Rehabilitation
Intensive Residential Treatment
Day Support
Mental Illness Management
Individual Therapeutic Support
Individual/Family Education and Support
Supervised Housing
Physician/Psychiatric Services
SMI Homeless Services
Drop-In Centers

Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Homes
Therapeutic Foster Care
Prevention/Early Intervention
Crisis/Emergency Mental Health Services
Mobile Crisis Response Services
Intensive Crisis Intervention Services
Case Management Services
Day Treatment
Outpatient Therapy
Physician/Psychiatric Services
MAP (Making A Plan) Teams
School Based Services
Mental Illness Management Services
Individual Therapeutic Support

Acute Partial Hospitalization
Family Education and Support

Services for People with Alzheimer's Disease and Other Dementia
Adult Day Centers

Caregiver Training

Services for People with Intellectual/Developmental Disabilities

Early Intervention
Community Living Programs
Work Activity Services
Supported Employment Services
Day Support
HCBS Attendant Care
HCBS Behavioral Support/ Intervention
HCBS Community Respite
HCBS In-home Companion Respite
Day Treatment
HCBS In-home Nursing Respite
HCBS ICF/MR Respite
HCBS Day Habilitation
HCBS Prevocational Services
HCBS Support Coordination
HCBS Occupational, Physical, and Speech/Language Therapies

Services for Substance Abuse

Detoxification Services
Primary Residential Services
Transitional Residential
Outreach/Aftercare
Prevention Services
Chemical Dependency Units
Outpatient Services
DUI Diagnostic Assessment

Facility Services

The types of services offered through the regional psychiatric facilities vary according to location but include:

Acute Psychiatric Care
Intermediate Psychiatric Care
Continued Treatment Services
Adolescent Services
Nursing Home Services
Medical/Surgical Hospital Services
Forensic Services
Alcohol and Drug Services
Community Service Programs

The types of services offered through the facilities for individuals with intellectual/developmental disabilities vary according to location but statewide include:

ICF/MR Residential Services
Psychological Services
Social Services
Medical/Nursing Services
Special Education
Recreation
Speech/Occupational/Physical Therapies
Vocational Training
Diagnostic and Evaluation Services
Employment Services
Community Services Programs

Description of State Mental Health Agency's Leadership

The DMH provides leadership in coordinating mental health services within the broader system, both within its organizational structure and in its relationships with other agencies. For example:

- The DMH is an independent agency, governed by a state board authority and has responsibility for a range of services for individuals with disabilities and their families, including mental health, intellectual/developmental disabilities, and substance abuse service, as well as for caregiver training and public day programs for persons with Alzheimer's Disease and other dementia. This administrative structure allows for leadership and better coordination of services, particularly for individuals with multiple disabilities.
- By state statute, the Executive Director of the MS DMH serves on the governing board of the MS Department of Rehabilitation Services, which facilitates additional collaboration and coordination of vocational rehabilitation services and activities with the services provided through DMH.
- The MS DMH routinely includes representatives of other agencies that provide

direct/support services to individuals with mental illness on advisory councils/task forces (such as the Department of Rehabilitation Services, the Department of Human Services, the Division of Medicaid, the State Department of Education, etc.) and similarly, assigns its staff to serve on committees/councils established by other agencies, as requested.

- The MS DMH works cooperatively with other agencies to implement federal programs administered by agencies that have a broader mission. Some examples include: working with MS Division of Medicaid to monitor/certify community mental health centers participating in the Medicaid Community Mental Health Services Program; working cooperatively with the Division of Medicaid, which is implementing a Community-based Alternatives Psychiatric Residential Treatment Facilities (PRTF) program for eligible youth with a serious emotional disturbance, one of 10 PRTF Demonstration Projects approved by the federal Centers for Medicare and Medicaid Services (CMS); and, working with the Department of Human Services (DHS) by monitoring and certifying community providers receiving funds from DHS for therapeutic foster care, Adolescent Offender Programs with a day treatment component, and therapeutic group home services.
- The Executive Director of DMH or designee also serves on other interagency committees designed to address overall health, disability and/or social services concerns, such as the Disabilities Resources Commission, the Interagency Council for Children and Youth, the Children's Trust Fund and the Pregnancy Risk Assessment Monitoring System (PRAMS).
- The MS DMH established and continues to provide flexible funding for a State-level Interagency Case Review Team for children with SED and for local Making A Plan (MAP) teams (described in the Plan), which address needs of youth with serious emotional disturbances with complex problems that typically involve multiple state agencies.
- The Executive Director of DMH and Director of DMH Division of Children's Services served as chairpersons of the Executive Level Interagency Coordinating Council for Children and Youth (ICCCY) and its mid-management team, respectively, during the first year of operation and in the current year of this legislatively-established interagency entity; both continued participation as members once their one-year terms as chairpersons expired.

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities for FY 2011

Service System's Strengths and Weaknesses

Strengths: Children's Services

- The Division of Children and Youth Services applied for and was granted funding for a third Children's Mental Health Initiative targeting transitional-age youth, 16-21 years. The Mississippi Transitional Outreach Program (MTO) will begin implementation October 1, 2010 in two Community Mental Health Center regions. On October 1, 2011 and 2012, two more regions will be added for a total of six MTOs 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.
- Efforts to increase and expand youth suicide prevention activities continued, including quarterly meetings of the Youth Suicide Prevention Advisory Council, implementation of the “Shatter the Silence” Campaign, training for newly licensed teachers and principals, and implementation of the ‘Talk About It’ campaign. AnComm’s ‘Talk About It’ service allows individuals to communicate anonymously via web or text with helpline staff from trained professionals through the Office of Constituency Services.
- 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.

Weaknesses: Children’s Services

- 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: Adult Services

- 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 elderly 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 is in the process of transitioning the operation of six of the seven crisis centers to the local community mental health centers to allow for more seamless admission and transition of individuals back to the local community. DMH also plans to continue funding two other intensive residential treatment programs operated in previous years by community mental health centers. Total capacity of all the centers will more adequately address a major unmet need for access to crisis intervention and stabilization services on a statewide basis.
- 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 that will facilitate training on effective assessment and treatment for co-occurring disorders in community mental health regions and state hospitals that have not received the training in the previous year.

- 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 Constituency Services (OCS). 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 OCS maintains a 24-hour, toll-free assistance line, as described in more detail in Section III. in both the Children's Services and Adult Services Plans.
- 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 continues to work 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.
- 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.
- 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.
 - 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) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year statewide Anti-Stigma Campaign. The first year of the statewide

campaign was launched on May 2, 2007, with a press conference in Jackson, MS. The campaign, which is entitled "What a Difference a Friend Makes," 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. Because the campaign targets the transitional age range, this transformation objective was included in FY 2008 through FY 2010 in both the Children's Services and Adult Services State Plans. 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 1 million individuals in FY 2008. In October 2009, DMH and the statewide Anti-Stigma Committee will launch a campaign specific to Mississippi entitled, "Think Again." The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. It will continue to show young adults how to support their friends who are living with mental health problems.

- In 2009, the DMH Division of Community Services continues work to develop and pilot three AMAP (Adult Make A Plan) Teams. Division of Community Services staff will collaborate with Division of Children and Youth Services staff to receive training on wrap-around services; the Division will also work with the person-directed planning training sites in Regions 12 and 15 to include this approach in AMAP training. 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.

Weaknesses: Adult Services

- 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.
- Development of a comprehensive strategic plan to expand housing options statewide for persons with serious mental illness is needed to support recovery.
- 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.

Analysis of Unmet Service Needs/Critical Gaps in Current System and Source(s) of Data Used to Identify Them: Children's and Adults' Services

The needs or critical gaps in the service system are reflected in the weaknesses listed in the previous section, as well as in the summary of areas needing particular attention described in Section I. Data and other information used to identify unmet needs/critical gaps in the service system are obtained from a variety of sources and processes. As mentioned, the Ideal System Models for a comprehensive service system for both children and adults describe service components that must be in place and accessible on a

statewide basis in order for the vision of the system to be realized. Analysis of the status of the availability and accessibility of service components depicted in the Ideal System Models, as well as adherence to underlying principles of family-centered and person-driven approaches, are ongoing.

DMH administrative staff also 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; a copy of the review report is also provided to the Planning and Advisory Council and the State Board of Mental Health.

As reflected in the State Plan, 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.). 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.

As mentioned, the DMH continues to rely on information gathered on availability and accessibility of specific services, availability and qualifications of staff, and training needs through direct contact made on frequent on-site monitoring visits of community mental health programs. Results of these on-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 minimum 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.

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 reviews the DMH's progress on implementation of state plan objectives, both during and at the end of every year. Major family and consumer advocacy groups continue to be represented on the Planning Council. The Council also established a Long-Range Planning Committee in June 2005 and made it a Standing Committee in August 2009; the committee is charged with making recommendations for

further advancing and sustaining community-based services and supports. Beginning in FY 2007, the Consumer Rights Committee of the Council surveyed stakeholders, including participants at the Consumer Conferences, for additional input on issues to focus their work and subsequently made recommendations to the full Council. 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 housing and transportation were identified.

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), the 2nd Comprehensive System of Care Project (commUNITY cares) in three counties of the state, and the 3rd Comprehensive System of Care Project (Mississippi Transitional Outreach Program), all of which are described in more detail in the State Plan.

As described in the State Plans for children and adults, the DMH management staff also receive regular reports from the Office of Constituency Services (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.

Priorities and Plans to Address Unmet Needs in FY 2011

a) Children's Mental Health System

Priority: Fetal Alcohol Spectrum Disorder

Plans: The Mississippi DMH continued its commitment to providing state-level leadership in providing information about FASD and identifying any potential resources for support of initiatives by designating a staff person in the Division of Children and Youth Services to serve as coordinator of these efforts. The major goal of the initiative is to improve the functioning and quality of life of children and youth and their families by diagnosing those with an FASD and providing intervention based on the diagnosis. This initiative targets children birth to seven years old who are referred to the local community mental health center because the child is exhibiting symptoms of an emotional or behavioral disturbance. The children who are screened and diagnosed as having a FASD diagnosis will receive individualized interventions and treatment based on their strengths and needs. Children referred to the UMMC Child Development Clinic for a FASD

diagnostic evaluation and who are diagnosed with FASD will be provided with FASD-specific treatment recommendations by the clinic director and diagnostic team. These recommendations will be incorporated into the child's treatment plan at the CMHC, with local MAP teams being responsible for ensuring that resources are available to carry out the treatment recommendations. This initiative will also serve to further identify those treatments and interventions that are most effective for children with FASD. The Division also plans to continue the annual FASD Symposium begun in 2003.

Priority: Staff Training

Plans: As described throughout the State Plan for Children's Services, particularly under Criteria 3 and 5, the DMH Division of Children and Youth Services plans to continue its emphasis on training to increase the skills of community services providers and to facilitate retention of staff, and therefore, continuity of care. The Division of Children and Youth Services also plans to continue its support and participation in statewide conferences that involve staff from other child and family service agencies, such as the Annual Lookin' to the Future Conference, the Juvenile Justice Conference, the conference of the MS Alliance of School Health (MASH), and other workshops to include youth suicide prevention, wraparound, system of care, evidenced-based practices, and interagency collaboration.

Priority: Working with Schools

Plans: Initiatives in the State Plan for Children under several criteria have as a component, working, training and/or networking with educational staff, both at the state and local levels. As noted under Criterion 3, the State Department of Education has implemented a system of focused monitoring of schools to identify areas in need of improvement, one of which includes identification of children with emotional disabilities. The DMH plans to continue to require community mental health centers to offer school-based services to local school districts; to provide technical assistance in the provision of school-based services, particularly working with case managers to better identify potential barriers to school attendance that might be addressed through the mental health treatment plan; to work with education staff on local MAP teams, the State –level Interagency Case Review Team and the Interagency Coordinating Council for Children and Youth; and, to encourage and support cross-training efforts across the mental health and education systems, both at the local and state levels. Additionally, the DMH Division of Children and Youth Services plans to continue forging a partnership with school-based primary health care providers, i.e. school nurses, through the MS Alliance for School Health at that organization's annual conference.

Priority: Expanding Evidenced-based Practices

Plans: The DMH plans to continue to track progress and products initiated through the Mississippi Trauma Recovery for Youth (TRY) project, implemented by Catholic Charities, Inc., which continues to be a member of the National Child Traumatic Stress Network (NCTSN). The goal is to improve the quality, effectiveness and availability of

therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward that goal, learning collaboratives focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) will continue to be developed as funds are available; 11 sites in Mississippi, including the Gulf Coast Mental Health Center, were involved in the initial learning collaborative. Currently, TRY is undergoing the first learning collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPRARCS), which is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may continue to be living with ongoing stress and are experiencing problems in several areas of functioning.

DMH Division of Children & Youth in collaboration with the Division of Medicaid has provided Wraparound and System of Care training through the Innovations Institute at the University of Maryland for providers of the SED Waiver Demonstration Grant and the MAP Team Coordinators. Plans are to implement this Wraparound model across the state as further training, technical assistance, and coaching is provided by staff from Innovations Institute.

Priority: Housing Supports for Families

Plans: In FY 2010, the DMH continued to work with the MAP teams to focus planning on increasing housing supports for youth with serious emotional disturbances, who may be living at home, but who are nonetheless, at risk for homelessness. Typically, these children have single mothers living at or below the poverty level. The team will continue to focus on transition planning at the inpatient/residential site for institutionalized children to facilitate more stable housing, potentially through other supports, such as education on financial management or adequate supervision of children at home that allows the mother to maintain employment. Additionally, efforts continue to focus on mothers and their children living in a domestic violence program/center and their transitioning back to the community with appropriate housing supports. The Director of the Mississippi Transitional Outreach Program (MTO) also serves on the Housing Task Force established by DMH in FY 2010.

Priority: Continued Interagency Collaboration Activities/System of Care

Plans: Local MAP teams will continue to serve as a point of contact for youth with serious emotional disturbances referred across child and family service agencies. The DMH will continue to provide flexible funding these teams in each of the 15 CMHC regions, to increase evaluation of their functioning and to provide additional training to and through the teams. The State-level Interagency Case Review Team will continue to function to address the needs of youth and families that cannot be addressed fully by local MAP teams. Additionally, the Interagency System of Care Council (ISCC) will continue to include a staff member representing the DMH Division of Children and Youth Services, who will also be the primary liaison with local MAP Team Coordinators and the State Level Case Review Team.

Priority: Interagency Efforts with Juvenile Justice

Plans: A DMH Division of Children and Youth staff member has been assigned as the Juvenile Mental Health Coordinator for the Juvenile Assistance Grant received by the Department of Public Safety. The Coordinator is identifying the current needs of the 17 local detention centers across the state and the community mental health centers regarding access to mental health services for those youth admitted in the detention centers.

The DMH plans to continue to provide technical assistance to and monitor Adolescent Offender Programs certified as day treatment programs. The programs (AOPs), as well as other AOPS that are not DMH-certified day treatment programs, are funded by the Department of Human Services and are designed to divert youth from training schools. The DMH will continue to operate a Specialized Treatment Facility for Youth with Emotional Disturbance to meet the needs of youth whose behavior requires specialized treatment.

Priority: Strategies to Meet the Needs of Youth in Transition

Plans: A Transition Age Task Force, which is chaired by the staff person who is also coordinating the division's work with youth in transitional ages in community-based services will continue to operate. The DMH also plans to continue funding that was redirected to support transitional living programs operated by the CMHC in Region 12 and by another nonprofit service provider, specifically targeting the needs of youth in transition and facilitating access to a variety of living situations/housing and supports, depending on the needs of the individual youth. These service providers have shared specific strategies with other service providers on the Transition Age Task Force.

DMH Division of Children & Youth received a 3rd Comprehensive System of Care Initiative in October 2009 that will target transition-aged youth, 16-21 years. The Mississippi Transitional Outreach Program (MTO) begins the first implementation year, October 1, 2010, in two community mental health center regions.

b) Adult Mental Health System

Priority: Consumer-directed Activities

Plans: The Division of Consumer and Family Affairs has identified dissemination of a philosophy of more individualized, person-directed assessment and treatment through training and follow-up with professionals and stakeholders involved in the process as key to realization of a recovery-oriented system. The objectives of the Division are as follows: (1) To ensure that consumers of mental health services and families of consumers of mental health services are the driving force for improvements in the publicly funded mental health system; (2) To help individuals and their families participate in the decision making at all levels of our public mental health system; and (3) promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services. The Division of Consumer and

Family Affairs plans to continue its focus on improving the peer review process to better assess if programs are recovery-oriented. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person-driven, evidence-based, recovery-oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011. The division also plans to continue supporting consumer education and support programs provided through NAMI-MS (such as Peer to Peer) and the Mississippi Leadership Academy. The Mississippi Leadership Academy was implemented in 2006, with over 100 participants thus far. Persons who have participated in Peer-to-Peer training, or other state supported educational trainings or who are interested in increasing their leadership skills will be provided an opportunity to participate in the Academy, as resources are available. In FY 2011, the Division of Consumer and Family Affairs will continue to work with other divisions in DMH to make available education and informational materials about recovery and empowerment. The division will also continue its work to develop the peer specialist program, including providing education to the mental health provider system about meaningful roles for peer specialists, as well as to explore the feasibility of training family peer specialists. Currently, Certified Peer Specialists are working to establish bylaws, goals and a mission statement for Recovery Now, a newly formed consumer coalition. In FY 2010, two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. In FY 2011, the Bureau of Community Services will continue to explore areas to employ Peer Specialists and educate community mental health systems on the role of Peer Specialists in the recovery process. In 2010, DMH applied for Mental Health Transformation grant through SAMHSA, which if funded, will include development of Peer Specialist employment and education opportunities for an increased number of consumers. Additionally, in FY 2011, the Division of Consumer and Family Affairs will continue activities to facilitate the establishment of an independent consumer coalition. In FY 2010, the Division of Family and Consumer Affairs collaborated with other groups to identify consumers interested in assuming leadership roles in developing a statewide consumer coalition and by seeking guidance on steps to move forward in forming and supporting the coalition, possibly through holding a retreat of identified consumer leaders to discuss forming and supporting a coalition. The Division of Consumer and Family Affairs will continue to work with the newly formed consumer coalition group, Recovery Now, by providing requested support and technical assistance.

Priority: Crisis Services

Plans: In FY 2010 DMH sought and received legislative approval to transition the remaining six state-operated crisis centers from operation by the state hospitals to operation by regional community mental health centers; one center had been transitioned as a pilot program in Grenada in FY 2009. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of the remaining six units. The DMH will continue collaboration and support of all seven crisis stabilization units, based on the redesign piloted in Grenada, which includes operation based on community-based standards for intensive residential programs and acute partial

hospitalization services. The DMH Division of Community Services plans to continue efforts on developing a structure that more effectively targets intensive supports to individuals being discharged from crisis intervention programs or inpatient psychiatric facilities, such as through development of transition planning teams at the hospitals that work closely with community mental health centers and individuals receiving services and if appropriate, with their families. DMH plans to continue support of transitional group homes and supervised living options in the north and central part of Mississippi.

Priority: Transportation

Plans: As described under the Significant Achievements in FY 2009 for Adults in Section I, the DMH Division of Community Services continued an initiative begun with the Division of Medicaid through a transportation committee that is seeking to maximize funding for and the use of transportation for individuals with disabilities. In general, as conceptualized in preliminary discussions, a coordinated system of transportation that involves more efficient and effective scheduling and dispatching of transportation resources to prevent duplication is envisioned. Such a system would ultimately provide individuals with more flexible options that are necessary for them to pursue goals of employment and more independent living arrangements in the community. The DMH Division of Community Services implemented a Rebalancing Initiative grant awarded by the federal Center for Medicare and Medicaid Services (CMS) to develop a coordinated system of transportation in two mental health regions of the state: Region 4, located in the northeastern part of the state, and Region 15, located in the west-central part of the state. Planning meetings have continued, and the Mississippi Transportation Coalition was established that includes key stakeholders, including major state agencies that provide and/or support transportation, advocacy groups and individuals receiving services. Following Hurricane Katrina, DMH was awarded a supplemental grant to coordinate transportation in Hancock County (Region 13) on the coast, which was severely impacted by the storm. Since that time, a coalition has been formed in Hancock County, made up of transportation providers and consumers from the Gulf Coast. The goal was to replicate the statewide transportation plan in Hancock County, where services were devastated by Hurricane Katrina. As part of the Coalition's planning work, two grants were funded for two years by the Mississippi Council on Developmental Disabilities to implement some of the recommendations of the Coalition for the statewide transportation system on a test basis. Also, as part of the Coalition's work on the coast, transportation services were set up in Hancock County. CMS funding of the Rebalancing Initiative for coordinated transportation planning ended in September 2008. The Mississippi Transportation Coalition, which includes DMH representatives, continues to meet and seek additional funding avenues to pilot strategies developed by the Coalition to address unmet transportation needs. Supported through funding from the TTI and the FY 2010 CMHS Block Grant increase, DMH will continue implementation of a project piloting a coordinated transportation effort in the state. DMH will purchase transportation services for individuals with mental illness to maximize employment, housing and other community inclusion activities

Priority: Specialized Services and Supports for Elderly Persons

Plans: As described in more detail in the State Plan under Criterion 1, the DMH Division of Community Services plans to continue to provide technical assistance to community programs that have implemented elderly psychosocial rehabilitation programs. As noted, the DMH committed part of its CMHS Block Grant funds to support a model training site that can serve staff from other sites in-state. Thus far, one training site has been established, and plans are to continue to make training available in north, central and south Mississippi. The Division of Community Services also plans continued collaboration with the Division of Alzheimer's Disease/Other Dementia, which provides specialized training for caregivers. Two training sites have been developed and an additional training site for nursing home programs was developed in Region 6. Expansion of elderly psychosocial rehabilitation programs is anticipated in FY 2010. DMH will continue the expansion and improvement efforts of specialized services for individuals who are elderly by maintaining three training sites across the state.

Priority: Additional Housing Options

Plans: The DMH plans to continue to help support and monitor the provision of a range of community living options for individuals with serious mental illness, including transitional residential programs, group homes and supervised housing, including recently certified transitional group homes in Region 3 for individuals with mental illness and mental retardation who have been frequent users of the justice system and the state psychiatric hospital system. Efforts to develop more housing options for individuals with serious mental illness will continue. The possibility of dedicating a staff position to address this significant need is under consideration. The Division of Planning in the Bureau of Community Services will continue to participate in the NASMHPD Housing Task Force and coordinate the Housing Task Force established by DMH in 2010. The DMH will also continue activities to build partnerships at the state and local level and to use specialized technical assistance supported by federal TTI funding to facilitate development of a strategic plan for housing.

Priority: Services for Individuals with Co-occurring Disorders

Plans: As described in the State Plan under Criterion 1, the DMH Division of Community Services plans to continue to provide financial support and technical assistance to community mental health centers to implement guidelines for specialized services for individuals with co-occurring disorders. The focus of activities will be on continued training and monitoring to facilitate implementation of a truly integrated system of care for persons with co-occurring disorders of mental illness and substance abuse. Also, as mentioned previously, the DMH plans to continue its state office activities to further develop and implement action steps that were included in a more specific, statewide strategic plan developed by state and local representatives with technical assistance from the national Co-occurring Disorders Center for Excellence (funded by SAMHSA). In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to ensure that uniform services are being provided to

individuals with co-occurring disorders of mental illness and substance abuse. In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to facilitate the provision of uniform, evidence-based services to individuals with co-occurring disorders of mental illness and substance abuse. The use of the *GAIN Short Screener* as a standard screening instrument will continue to be required, and the federal Transformation Transfer Initiative to facilitate training on effective assessment and treatment of co-occurring disorders in community mental health regions and state hospitals that have not received the training in the previous year will continue.

Priority: Psychosocial Rehabilitation Programs

Plans: The DMH plans to expand ICCD-certified clubhouse programs to a minimum of one per region and to explore incentives to programs to achieve that ICCD status.

Priority: Training of Law Enforcement/Other Emergency/Health Personnel

Plans: As described in more detail under Criterion 5 in both the Adults' and Children's Services Plans, the DMH plans to maintain the availability of training for law enforcement personnel and monitor the provision of other training provided at the local level to address the needs of other emergency services personnel. An additional initiative related specifically to better assessing and treating trauma among children/youth is also described in the Children's Services Plan. Because of budget restrictions, DMH will not continue funding provided in FY 2010 for law enforcement training provided by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers and explore other avenues for funding and training for law enforcement and other emergency services personnel and to explore additional opportunities to divert and/or decrease involvement of individuals with mental illness in the criminal justice system. DMH will also collaborate with local law enforcement and community mental health centers in the development of Crisis Intervention Teams (CIT).

Priorities and Plans to Address Needs Across Children's and Adults' Mental Health Systems

Priority: Data Infrastructure Improvements

Plans: As described under Criterion 5 in both the Children's and Adults' Services Plans, the DMH is continuing its efforts to conduct a planning and data mapping process necessary to construct and implement a central data repository for public mental health information management at the DMH Central Office. It is anticipated that this process, which will enable the state to report federal Uniform Reporting System (URS) information, will be continued in FY 2011. The DMH will also continue to implement statewide assessment of satisfaction of adult consumers and families of children with the services they receive through the public community mental health system. Funds from a federal Data Infrastructure Grant (DIG) Quality Improvement project provided by CMHS will continue to be used to support this process, which will ultimately facilitate better

availability, quality and integration of process and outcome data needed to support ongoing work of the Planning Council and other quality improvement efforts. If its application for another three years of funding for the data infrastructure project is funded, DMH will pursue project plans to refine and implement a strategic plan for reporting client-level data for the National Outcome Measures targeted by CMHS, for refining infrastructure and processes for data collection and reporting, as well as for improving data integrity.

Priority: Continued Involvement of Individuals Receiving Services and Families

Plans: As noted throughout the State Plan, the DMH plans to continue involvement of consumers and family members through numerous task forces, the peer review process, and the MS State Mental Health Planning and Advisory Council. Structured orientation of new Planning Council members will be continued, as well as administrative support of the Council and its committees. As mentioned, the MS State Mental Health Planning and Advisory Council established an ad hoc Long-Range Planning Committee in FY 2005, which includes individuals receiving services and family members, to explore in more depth needs, issues and recommendations for continued development of community-based services and supports. With Council approval, the committee was extended into FY 2010, and a recommendation for extension and expansion of the committee's work to include continuity of care issues will be presented to the full Council. The Consumer Rights Committee and the Children's Services Task Force, both of which include consumers and family members, will also continue their work in FY 2011.

Priority: Cultural Competence

Plans: As described in both the Children's Services and Adults' Services Plans, the DMH plans to continue its commitment to both require and provide training in cultural diversity. The DMH plans to continue operation of the Multicultural Task Force, with continued focus on assisting local providers in assessing the cultural competence of their organizations and to plan to address the results of those assessments. The task force has also developed a draft model statewide cultural competence plan for the service delivery and organizational levels.

Priority: Training

Plans: The DMH plans to continue its work to implement a training and credentialing program for staff who work in the public mental health system and are not covered by any other credentialing programs. The DMH also plans to continue to implement training and credentialing for public mental health administrators and for case managers. (See Criterion 5.) The DMH plans to continue to work with the University of MS Medical Center (UMC) Department of Psychiatry and Human Behavior to continue implementation and development of cooperative psychiatry training programs at MS State Hospital and in community-based service settings.

Priority: Wrap Around Services

Plans: In 2010 the DMH Division of Community Services will continue work to pilot three AMAP (Adult Make A Plan) Teams in community mental health regions 6, 7, and 8. The programs are in initial stages, developing community partnerships with interested agencies/organizations. The Division will continue funding this effort and will begin exploring funding avenues to expand AMAP services into other CMHC regions. The Division of Community Services for adults will continue to collaborate with the Division of Children and Youth Services, which has implemented Making A Plan (MAP) teams for youth in all 15 regions, to receive training on wrap-around services. The Division of Community Services will work with person-centered planning training sites in Regions 12 (Pine Belt Mental Healthcare Resources) and 15 (Warren-Yazoo Mental Health Services), to address a person-directed philosophy as part of this training for AMAP team development. The Division of Children and Youth Services has partnered with the Division of Medicaid to provide Wraparound training to MAP Team Coordinators and other providers utilizing the model of the Innovations Institute at the University of Maryland. DCS hopes to maintain funding to Regions 6, 7, and 8, for AMAP teams, which are modeled on the MAP teams for children, but are designed to meet the needs of adults.

Priority: Monitoring of Use of Financial Resources

Plans: The DMH plans to maintain its system of internal fiscal and property auditing within programs it directly operates. The DMH Division of Audit in the Bureau of Administration plans to continue their activities to monitor use of resources by all local providers certified and funded by DMH to assure that the DMH-funded activities of the sub recipients are in compliance with applicable laws, regulations, policies, and procedures.

Summary of Recent Achievements that Reflect Progress toward the Development of a Comprehensive Community-based System of Care

Significant Achievements – Children’s Services:

MAP Teams: County Making a Plan (MAP) teams continued in the state, with representatives from key child and family services agencies at the local level reviewing the needs of children with serious emotional disturbance who were at imminent risk of inappropriate placement out of home. Coordinators of these MAP teams also have continued to meet on a monthly basis to further identify needs and develop resources in local communities. Thus far, 37 MAP teams have been developed statewide with and without DMH funding. The goal of this initiative is to expand the availability of these teams in areas of the state that do not have access to a MAP Team and to make flexible funds available.

Evidenced-based Practices: DMH continues to provide CMHS Block Grant funding for additional mental health therapists across the state to be trained through the learning

collaborative model by Catholic Charities, Inc. Trauma Recovery for Youth (TRY). Since 2007, learning collaboratives for Trauma Focused Cognitive Behavioral Therapy (TF-CBT) have continued training of therapists. Currently, Catholic Charities TRY is facilitating the first learning collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS).

Training: The DMH Division of Children and Youth Services staff continued to provide training and technical assistance at the local level and to co-sponsor or participate in statewide conferences involving other child and family service agencies, including the Mississippi Institute of School Health, Wellness and Safety; the annual Juvenile Justice Symposium; and, the annual “Lookin’ to the Future” Conference. Additionally, Division of Children and Youth staff have focused training on Fetal Alcohol Spectrum Disorders, Mississippi System of Care legislation, MAP Teams, youth suicide prevention, juvenile mental health, respite services, family involvement and education, and interagency collaboration. Staff have presented these topics to case managers, MAP Team members, Department of Health social workers and nurses, youth court judges and defenders, Department of Human Services social workers, and community mental health center therapists.

School-based Services: In FY 2010, the DMH Division of Children and Youth Services continued to monitor the implementation of school-based services by CMHCs, including school-based outpatient and day treatment services. School-based outpatient services were provided by the 15 CMHCs, and school-based day treatment services were provided by 13 of the 15 CMHCs. Two CMHCs also continued to utilize therapeutic nurses based in the schools to provide ongoing physical/medical care to children with serious emotional disturbances who receive outpatient mental health services.

State-Level Interagency Collaboration: The State-Level Interagency Case Review Team continued to receive flexible funds to support services for children/youth reviewed by the team and for whom funding and/or other resources were not identified as accessible at the local level, including youth who reside in counties without MAP teams. The Interagency Coordinating Council for Children and Youth (ICCCY), established by state legislation in 2001, has continued operation and was extended by state legislation until 2010. HB 1529, passed during the 2010 Regular Session expands the ICCCY and the Interagency System of Care Council (ISSC) to include the Attorney General’s office, youth/young adults, parent or family members, early childhood education representative, MAP Team Coordinators, professors, and a psychiatrist. This state-level collaborative team continued in FY 2010 to be a significant part of the overall interagency team structure that includes local MAP Teams in addressing the population defined by the legislation.

Transitional Services: The MS DMH continued funding for two Transitional Outreach Programs (P-TOP) in Region 12 (Pine Belt Mental Health Care Resources) and in Hinds County (MS Children’s Home Society), which supports the provision of mental health services needed by youth, ages 16-21 years of age, in a transitional living program. DMH Division of Children and Youth received a six-year Comprehensive System of Care Initiative Cooperative Agreement beginning October 1, 2009 that will provide

services and the necessary supports to transitional-age youth, 16-21 years in six community mental health centers across the state.

Juvenile Justice: DMH Division of Children and Youth continued to certify those Adolescent Offender Programs operated by the community mental health centers for the provision of day treatment services. The Division continued to provide technical assistance and updates to the Youth Court judges and certified Juvenile Defenders at their annual training. Additionally, the Division received grant funding from the Department of Public Safety to address the mental health needs of those youth detained in the 17 Detention Centers and two holding facilities. During this two-year initiative, needs assessments and forums will be conducted to determine the gaps between detention centers and access to mental health services. Funds will be available to support increased access to a mental health professional and to train detention center staff in crisis prevention.

Fetal Alcohol Spectrum Disorders Project: DMH Division of Children and Youth Services continued to implement a SAMHSA funded FASD contract with Northrup Grummond to provide statewide screening, assessment, and treatment of children (ages 0-7) with a FASD. This project continued to coordinate FASD Diagnostic and Assessment Services through the University of Mississippi Medical Center. The project director and staff traveled across the state to provide training and technical assistance to all 15 community mental health centers as well as provided flexible funds for the services and resources needed by the child and their family to increase functioning in their local communities.

Significant Achievements – Adults

Family Education and Support The DMH continues to provide support for the implementation of the Family-to-Family Education Program in Mississippi and anticipates that the number of family members who are trained to hold education classes and to provide support groups will continue to increase.

Consumer Education The DMH continues to provide support for the implementation of NAMI Peer to Peer Program, the Mississippi Leadership Academy and other approved consumer education programs in Mississippi, which includes training of trainers and provision of consumer education classes.

Specialized Programs for Elderly Persons The DMH Division of Community Services continues to provide technical assistance to local community mental health programs that are establishing elderly psychosocial rehabilitation programs, including implementation of a model training program. Efforts have focused on maintaining availability, improving the quality and facilitating further development of psychosocial rehabilitation services for elderly persons, including community-based programs and newly-developed services provided in nursing homes, throughout all service regions of the state. Staff in the DMH Division of Community Services also continue to collaborate with the DMH Division of

Alzheimer's Disease/Other Dementia in planning and hosting what has become an annual conference on Alzheimer's Disease and Psychiatric Disorders in the Elderly. In 2008, the Division of Community Services continued an elderly psychosocial rehabilitation program training site in Region 15 (Warren-Yazoo Mental Health Services) and added an additional training site in Region 12 (Pine Belt Mental Healthcare Resources). In FY 2009, the Division of Community Services continued support of an elderly psychosocial rehabilitation program training site in Region 15 (Warren-Yazoo Mental Health Services) and Region 12 (Pine Belt Mental Healthcare Resources). DMH also added a training site in Region 6 (LifeHelp).

Other Psychosocial Rehabilitative Services The DMH Division of Community Services continues to support technical assistance and training at an International Center for Clubhouse Development (ICCD) model program site in Region 5 (Greenville) to improve the quality of clubhouse psychosocial rehabilitation programs throughout the state. Training has included the transitional employment component of the program. The clubhouse program in Region 6 (Greenwood) also has ICCD certification, and Region 12 CMHC, Pinebelt Mental Healthcare Resources (Oasis Clubhouse), is currently seeking ICCD Certification. DMH plans to expand ICCD-certified clubhouse programs at a minimum of one in each region.

Case Management The DMH continues to provide support for case management services, including intensive case management. Case management orientation also continues to be a requirement for case managers in all regions of the state, and the MS DMH has developed a structured case management credentialing program. DMH has also continued review of minimum standards for mental illness management services (MIMS), individual therapeutic support and intensive case management for needed revisions to enhance person-directed services (person-centered planning). In 2008, person-centered planning was added to the case management orientation provided by the Department of Mental Health. In FY 2009, person-centered planning continued to be included in Case Management Orientation provided by the Department of Mental Health. DMH plans to offer an online, self study credentialing program for case managers.

Specialized Programs for Persons with Mental Illness who are Homeless The DMH Division of Community Services continued to allocate federal PATH funding to six program sites in Mississippi, based on results of a needs assessment. DMH Division of Community Services staff continue to participate in a workgroup established by the DMH and focusing on the needs of individuals who are homeless; staff are also involved in three additional interagency coalitions addressing homelessness/housing; they will also coordinate implementation of the SOAR Technical Assistance in FY 2010 and FY 2011.

Services for Individuals with Co-occurring Disorders of Substance Abuse and Mental Illness The DMH Division of Community Services continues its work through a Co-occurring Disorders Task Force with the DMH Division of Alcohol and Drug Abuse and the Division of Children and Youth Services in supporting the provision of specialized services and staff training in the area of co-occurring disorders of serious mental illness and substance abuse. Technical assistance from the national Co-Occurring Disorders

Center for Excellence (COCE) funded by SAMHSA, facilitated development and initiation of activities in a *Strategic Plan for Co-occurring Disorders* addressing all age groups. In May 2006, the DMH applied to SAMHSA for a competitive Co-Occurring State Incentive Grant (COSIG) to further develop the infrastructure for statewide training and implementation of evidence-based screening, assessment and treatment for individuals with co-occurring disorders; however, that proposal was not funded. With support from the federal TTI initiative, DMH will continue making training available in providing effective screening, assessment and treatment for individuals with co-occurring disorders of mental illness and substance abuse.

Continued Monitoring of Programs and Peer Review The DMH Division of Community Services continues its work to regularly conduct on-site visits of programs to monitor for compliance with minimum standards for community mental health services, a comprehensive review of which is currently underway. The DMH also continues to support a peer review process that includes family members, consumers, and service providers in on-site visits to community mental health services programs. Changes to the peer review process incorporate feedback from stakeholders and will support transition to a recovery-oriented system of services and supports.

State's Vision for the Future

“Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities one person at a time” is the mission of the Mississippi Department of Mental Health. The State Plan reflects the elements of the Department of Mental Health’s mission and vision as set forth in the Mississippi Board of Mental Health’s and the Mississippi Department of Mental Health’s overall *Strategic Plan, FY 2010-2020*, which was approved by the Board in June 2009: equal access to quality mental health care, services and supports in the community; active participation by consumers in designing services; elimination of stigma; and enhancement of prevention, care, services and supports through the application of research, outcome measures and technology.

The Mississippi Department of Mental Health’s Ideal System Model incorporates and reflects commitment to the mission, vision, core values and guiding principles of the agency. Individuals receiving services, each with his or her individual strengths and needs, is the center of the agency’s ideal system model. Central to the comprehensive public mental health service system is the belief that individuals are most effectively treated in their community and close to their homes, personal resources, and natural support systems. The development of the system reflects integration of services to meet individual needs and to facilitate accessibility and continuity of care. In meeting individual needs throughout the system, emphasis is placed on preserving individual dignity and rights including privacy and confidentiality, in the most culturally appropriate manner. The state’s vision for a statewide person-driven, family-centered system emphasizes the importance of access and coordination with other service agencies. System-wide support services may include operational services provided through a variety of other agencies or entities. Inherent in the Ideal System Model are the

characteristics of consistency, accountability, and flexibility, to allow responsiveness to changing needs and service environments.

Section III: Performance Goals and Action Plans to Improve the Service System

(a) FY 2011 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Criterion 1: Comprehensive Community Based Mental Health Systems - The plan-

- **Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness**
- **Describes available services and resources in a comprehensive system of care. This consists of services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities,**
- **including services for individuals diagnosed with both mental illness and substance abuse.**

Ideal System Model

The development of children's mental health services in Mississippi was established as a priority of the Department of Mental Health in 1980, through the State Board of Mental Health's creation of a Division of Children and Youth Services within the Bureau of Mental Health. The Department and the MS State Mental Health Planning and Advisory Council developed an Ideal System Model for the Mississippi Comprehensive Community Mental Health System for Children with Serious Emotional Disturbance (see Figure that follows), upon which long-term goals were based. Realistic annual objectives have been formulated to address gaps in the system, given available human and fiscal resources, while efforts to sustain and increase resources have been ongoing. All goals and objectives continue to represent ongoing efforts to develop a comprehensive system of care for children represented by the Ideal System Model for community-based services. The time line for all objectives in the FY 2011 plan for children is October 1, 2010, through September 20, 2011.

The Ideal System Model communicates the state's vision for a statewide, child- and family-centered system of care, which emphasizes the importance of access and coordination with other child and family service agencies. An array of community-based services, including a variety of outpatient, day and community residential mental health service options encircle the child and the family in the Ideal System Model. Key to access and coordination is case management, which has been a focus of expansion of children's mental health services. Since the Ideal System Model is community-based, built on the belief that children and families should be served as close to their homes and natural support systems as possible, therapeutic support services and advocacy systems are key among the service components of the ideal system. Thus, the system recognizes the critical importance and expertise of parents in identifying and meeting the needs of children with serious emotional disturbance and the value of facilitating the development of family education, support and advocacy networks.

System-wide support services may include services for which agencies or entities other than the state mental health agency are the primary providers, such as educational services, medical services, dental services, financial assistance or certain social services. The Ideal System Model

is based on a broader vision of an interagency network of services or system of care, in which the mental health system interacts with the other child and family service systems. In this ideal system of care, the focus should be on the functioning of each of the systems in the network to meet individualized needs of the child and family, thus making them all child- and family-centered. System-wide support services may also include some operational services that may be provided through a variety of other agencies or entities, such as transportation or volunteer services. (Stroul and Friedman, 1986).

Services for Youth with Co-occurring Disorders (substance abuse and mental illness)

System-wide support services now include an array of substance abuse services administered by the Department of Mental Health. The inclusion of substance abuse services as a system-wide support emphasizes the Division of Children and Youth Services' intent to expand and strengthen linkages that make substance abuse services more accessible and responsive to the needs of youth who also have a serious emotional disturbance.

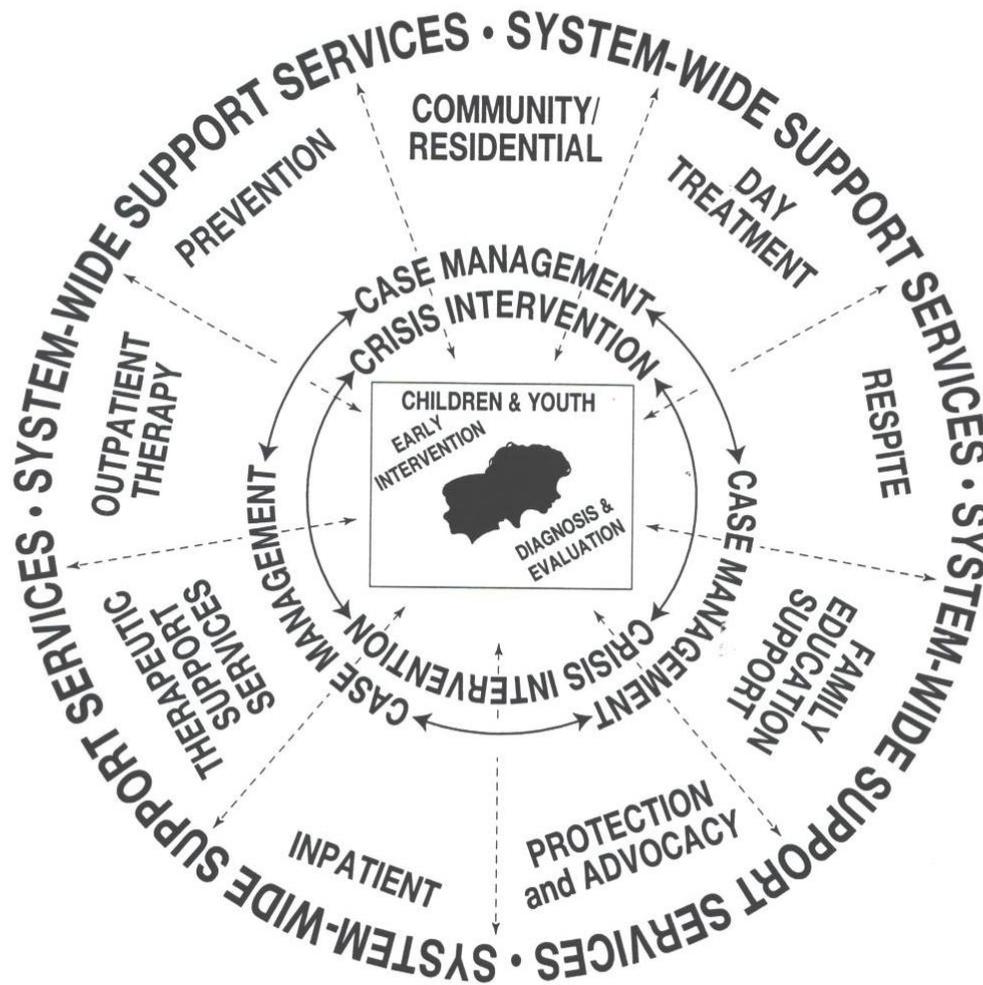
The mental health and support system components of the system are more likely to change as the needs and strengths of children and families change. Inherent in the Ideal System Model are the characteristics of consistency, based on service philosophy and values, and flexibility, to allow for responsiveness to changing needs and service environments.

The major service components of the Ideal System Model For Children include: prevention, early intervention, diagnosis and evaluation, case management (school-based case management, individual therapeutic support, and mental illness management services), crisis intervention, outpatient services, day treatment, respite services, community-based residential services, protection and advocacy, family education and support, inpatient services, other support services, and system-wide support services.

Efforts to enhance interagency collaboration, including operation of a State Level Interagency Case Review/MAP team, local interagency MAP (Making a Plan) teams, and in more recent years, the Interagency Coordinating Council for Children and Youth (ICCCY) reflect the establishment of structures that build on families' strengths while addressing the special needs and circumstances of children. The Plan also describes continued efforts to increase the availability, accessibility and quality of children's services across the 15 community mental health regions.

IDEAL SYSTEM MODEL

Mississippi Comprehensive Community Mental Health System
for
Children With Serious Emotional Disturbance



CHARACTERISTICS OF THE SYSTEM

- Child and Family-Centered
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- System is Community-Based
- Emphasizes Both Service Availability and Advocacy and Support Networks

Organizational Structure and Development of the Comprehensive System of Care

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 community mental health centers began providing outpatient services to children and adolescents with serious emotional disturbance as Medicaid reimbursable services in 1986 and served 29,269 children/youth with SED in FY 2008.

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.

The Children's Health Insurance Program (CHIP) also includes inpatient and some outpatient mental health services, as well as substance abuse services from approved providers, within specified limits. Mental health services include outpatient care. Precertification/prior authorization for inpatient care and partial hospitalization by network provider is required.

Federal and State Resources

The FY 2011 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2010 Session. Also included under Criterion #5 in the Children's Plan and in the Adult Plan are objectives to request additional state funds for the 2012 fiscal year. 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 also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) If SSBG funding, which totals \$1.2 million for mental health services for adults and children, is no longer available in FY 2011, modifications to the plan may be required. The DMH also 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 the past nine 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. In FY 2011, projections are that between \$24 and \$32 million will be needed for match on CMHC Medicaid payments; the higher amount will be needed if the enhanced federal share of Medicaid under ARRA is not extended until June 30, 2011.

Sources listed under the heading of “Funding” within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under “Funding” does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited.

System of Care Development

Since system development historically has emphasized interagency collaboration, most objectives pertaining to system of care development are included under Criterion 3. As is evident throughout this plan, the process of development of the system of care in Mississippi has involved many concurrent and overlapping initiatives, during the past decade. Since 1980, the development of the system of care has involved cooperative administrative and policy changes at the state and local levels, which in some areas were facilitated by legislation. The Ideal System Model is based on a philosophy of services reinforced in the state through the implementation of statewide and local Child and Adolescent Service System Projects (CASSP) in the mid-1980’s and the 1990’s. DMH and the MS State Mental Health Planning and Advisory Council, including the Children’s Services Task Force of the Planning Council, have worked to develop program components within that system model.

Mental Health Transformation Activities: Improving Coordination of Care Among Multiple Systems

The **State-Level Interagency Case Review/MAP Team** has continued to serve as an effective mechanism for major child and family service agencies to work together at the state-level to resolve difficult issues specific to individual children with serious emotional disturbance. Agencies’ work on the team keeps them informed of the needs of families and youth with the most intensive needs, which facilitates their involvement in further development of a comprehensive system.

Wrap-Around Approach and Local MAP Team Development: The concept of using first the State-level Interagency Case Review Teams to address the needs of youth with a history of or at high risk for hospitalization or institutionalization has continued to be a major strategy in development of the system of care. Initial efforts to pilot this system-based wraparound approach in the state at the local level were through the Mississippi Connections project utilizing a designated amount of state resources from major child/family service agencies (representing mental health, human services (child welfare), education, health and Medicaid).

Mississippi Families As Allies for Children’s Mental Health, Inc. (MS FAA) and Pinebelt Mental Healthcare Resources (Region 12 CMHC) are partners with the DMH Division of Children and Youth Services in leadership, staffing, and support of the five-year project, which has been named

commUNITYcares (uniting neighborhoods – integrating through youth). This project is in its third year of implementation, during which services are being provided through the wraparound process for children affected by severe emotional disturbance (SED) and or co-occurring SED and substance misuse in a region of the state (Forrest, Lamar and Marion counties) that has high need for, but low availability of services that could have also served as a model for other rural areas. DMH, Division of Children and Youth Services was also awarded a six-year System of Care grant October 1, 2009, that will focus on the development of services and programs for transition age youth (16-21 years) in six community mental health center regions across the state.

Mental Health Transformation Activity: Supporting Individualized Plans of Care (NFC Goal 2.1)

In Mississippi, as the concept of wraparound is implemented further, it is expected that individualized service plans be designed through a family- and child-driven, strengths-based needs assessment process. A team, including representatives of the family and various child and family service providers, develops the initial service plan for a child. The wraparound process, as demonstrated by the COMPASS project and commUNITYcares, takes advantage of an interagency, interdisciplinary approach through which some providers have access to flexible, non-categorical funding. Additionally, local interagency and family Making a Plan (MAP) teams will continue to be supported in implementation of a strengths-based assessment approach that leads to use of the child's and family's strengths in defining and providing an appropriate, coordinated array of services and supports. Presently, community mental health children's service providers in 15 CMHC regions of the state are using this approach through MAP teams. Currently, there are 37 MAP Teams with plans for expansion in FY 2011.

MAP Team Coordinators meet bimonthly to obtain further training and technical assistance from DMH Division of Children & Youth Staff or representatives from other child serving agencies, and Mississippi Families As Allies for Children's Mental Health, Inc. In FY 2010, MAP Team Coordinators and their local members, family/parent groups, as well as members of the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC) participated in the development of the Mississippi System of Care Assessment and Study. This study, coordinated by the Center of Mississippi Health Policy, gathered stakeholder and family input for the revision of the MS System of Care legislation, HB 1529 which passed during the 2010 Regular Session.

Quality Improvement System Development

Some of the specific parameters of the Mental Health Reform Act (Senate Bill 2100) passed during the 1997 Session of the Mississippi Legislature that continue to impact development of the system of care for children/youth with SED are those provisions that address uniformity of services, establishing interagency agreements, timeliness of services, crisis services, and overall accessibility of services. The Department of Mental Health continues to implement various provisions of SB 2100, which is expected to increase the availability and uniformity of community-based services statewide. Consistent with the call for increased access, quality and accountability of services in the Mental Health Reform Act, the Mississippi Department of Mental Health continues work to improve its system of program evaluation and planning, a key

focus of which is further development of its data infrastructure and information management systems. 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).

Goal: To continue development of the program evaluation system, including implementation of the requirements of the Mental Health Reform Act of 1997 (SB 2100), to promote accountability and to improve quality of care in community mental health services.

Peer Review

In addition to monitoring community mental health service providers' compliance with minimum standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in children/youth mental health services from among staff at community programs certified by the DMH. In FY 2008, the Division of Consumer and Family Affairs was created and took on the responsibility of coordinating the peer review process for adult services and children's services. Based on feedback from satisfaction surveys in FY 2008, revisions were made to improve the peer review process for FY 2009. Peer review visits in FY 2009 involved a smaller, more focused team of one consumer representative, one family member and one stakeholder. During the review, a sample of each type of program is visited. The Division developed a manual/guide for Peer Reviewers that describes available services by region, and core services; thumbnail images of service locations were placed next to addresses. A pre-conference visit is also held with service providers, in addition to the exit conference at the close of the visit. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person-driven, evidence-based, recovery-oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011.

Goal: To continue development of the program evaluation system to promote accountability and to improve quality of care in community mental health services.

Objective: To refine the peer review/quality assurance process for all community mental health programs and services based on survey responses from community mental health center directors, peer reviewers, and interested stakeholders.

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system

Brief Name: Peer review of children's mental health services.

Indicator: A Recovery Self Assessment (Assessment) tool, adapted for applicability to children's services, has been developed to measure transformation from a traditional mental health service system to a recovery-oriented system of care. The primary goal of the assessment is to provide a tool that assists stakeholders to

consistently track transformation activities in accordance with the Department of Mental Health's vision of developing a person driven, recovery oriented system of care.

Measure: Development of a Recovery Self Assessment tool to measure movement from the traditional model to a recovery oriented system of care.

Source(s) of

Information: Peer review reports, which are mailed to the certified/funded community mental health children's services providers.

Special

Issues: The teams will conduct an assessment with the programs utilizing the Recovery Self Assessment guide after a self assessment has been completed by the community mental health center, state hospital, and/or private program.

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Results of the peer reviews make available to providers additional information/technical assistance specific to their programs that can be used to improve services. The Recovery Self Assessment tools will allow the Department of Mental Health to assess how the community mental health centers and state hospitals identify strengths that already exist and acknowledge areas that require enhancement and further development.

Funding: CMHS Block Grant Funds

Mental Health Transformation Activity: Involving Families Fully in Orienting the Mental Health System Toward Recovery (NFC 2.2)

National Outcome Measure: Client Perception of Care – Outcomes

Goal: To improve the outcomes of community-based mental health services

Target: Increase or maintain percentage of parents/caregivers of children with serious emotional disturbance who respond positively about outcomes

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system

Indicator: Parents/caregivers of children with serious emotional disturbance responding to a satisfaction survey who respond positively about outcomes

Measure: Percentage of parents/caregivers who respond positively on items in the outcomes domain of the *Youth Services Survey for Families (YSS-F)*

Sources

of Information: 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).

Special

Issues:

Piloting of the Youth Services Survey for Families (YSS-F) began in FY 2004. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC) to administer the official version of the *YSS-F* to a representative sample of parents of children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region beginning with the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions.

Significance:

Improving the outcomes of services for children with serious emotional disturbances receiving services from the perspective of parents/caregivers is a key indicator in assessing progress on other goals designed to improve the quality of services and support family-focused systems change.

Action Plan:

Examples of initiatives to disseminate and expand the use of evidence-based practices include: the participation of several community mental health centers/other nonprofit service providers in learning collaboratives to provide training for implementation of trauma-focused cognitive behavior therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); the provision of training to staff at Gulf Coast Mental Health Center (Region 13 CMHC) in Child-Parent Combined CBT, Trauma Assessment Pathways (TAP), and Psychological First Aid; and, the provision of staff training in CBT and TF-CBT as part of the commUNITY cares System of Care project in the Pine Belt Mental Healthcare Resources service area. Initiatives such as the operation of MAP teams and family education/support activities that facilitate involvement of parents/caregivers will also be continued.

Satisfaction Survey of Parents/Caregivers of Children with Serious Emotional Disturbances Receiving Community Services

National Outcome Measure: Client Perception of Care – Outcomes of Services Domain
(URS Basic Table 11)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% Reporting Positively about Outcomes for Children	66%	65%	69%	67%	67%
Numerator	195 positive responses	198 positive responses	514 positive responses	206	
Denominator	296 responses	305 responses	742 responses	309	

Overall Results of Satisfaction Survey:

Results from the *Youth Services Survey for Families (YSS-F)* indicate perception of care about major domains of service, in addition to the National Outcome Measure on outcomes of services (described above). These domains include: access, general satisfaction, participation in treatment planning, and cultural sensitivity of staff, and are indicated in the following table.

Satisfaction Survey of Parents/Caregivers: Client Perception of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
1. % Reporting Positively about Access	90%	87%	90%	91%	89%
Numerator	264 positive responses	264 positive responses	667 positive responses	279 positive responses	
Denominator	294 responses	303 responses	742 responses	308 responses	
2. %					

Reporting Positively about General Satisfaction	89%	88%	87%	89%	88%
Numerator	263 positive responses	266 positive responses	651 positive responses	275 positive responses	
Denominator	297 responses	303 responses	745 responses	309 responses	
3. % Reporting Positively about Outcomes for Children	66%	65%	69%	67%	67%
Numerator	195 positive responses	198 positive responses	514 positive responses	206 positive responses	
Denominator	296 responses	305 responses	742 responses	309 responses	
4. % Reporting on Participation in Treatment Planning for their Children	87%	86%	89%	86%	87%
Numerator	255 positive responses	261 positive responses	662 positive responses	265 positive responses	
Denominator	294 responses	303 responses	741 responses	308 responses	
5. % Reporting High Cultural Sensitivity of Staff (optional)	95%	95%	94%	95%	94%
Numerator	280 positive responses	290 positive responses	701 positive responses	295 positive responses	
Denominator	295 responses	305 responses	744 responses	309 responses	

Mental Health Transformation Activity: Implementation of Consumer Information and Grievance Reporting System (NFC Goal 2.5)

The Office of Constituency Services 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. Through mid-FY 2010, OCS has received 6497 calls on the Suicide Prevention Lifeline. 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 Minimum Standards for Community Mental Health/Mental Retardation Services* 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 minimum standards monitored by OCS. These modules are available as requested by any DMH-certified program.

In FY 2010, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities). Additionally, OCS continues to publish, distribute, and update the "Directory on Disk" program to all DMH facilities and community mental health centers, as well as DMH Central Office staff. This directory gives service providers access to basic program/ service information for over 2700 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the statewide database used for information and referral (approximately 45 new programs were added and over 344 individual programs' information has been updated in FY 2010); this process is also ongoing.

Objective: 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.

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system.

Brief Name: Constituency Services Call Reports

Indicator: 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.

Measure: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports).

Source(s) of

Information: Data provided through the software, as calls to the OCS help line logged into the computer system.

Special

Issues: Dissemination of the directory on disk (a read only version containing program information) is being provided only to DMH-certified and funded providers who sign a use agreement to ensure preservation of accurate and current data.

Significance: The establishment of a toll-free grievance telephone reporting system for the receipt (and referral for investigation) of all complaints by clients of state and community mental health/retardation facilities is a provision of the Mental Health Reform Act of 1997. The concurrent development of a computerized current database to also provide callers with information and assistance facilitates access to services by individuals expands the availability of current and detailed statewide service information to community mental health centers.

Funding: State General Funds

Children's Mental Health Program Standards

Division of Children and Youth Services staff will continue to conduct certification visits to community mental health service providers to review compliance with DMH *Minimum Standards for Community Mental Health/Mental Retardation Services*. Technical assistance on system of care development continued to be available to children's mental health service providers in FY 2008 and FY 2009. During FY 2009, Division of Children and Youth staff also participated in several DMH committee meetings to begin revising the 2002 *DMH Minimum Standards*.

Other Systems Development Initiatives

Mississippi Youth Programs Around the Clock (MYPAC): Community-based Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant

In FY 2004, the MS Division of Medicaid, in coordination with the Department of Mental Health, was awarded a federal grant from the Centers for Medicare and Medicaid Services (CMS) designed to promote Community-Based Treatment Alternatives for Children (MS C-TAC). With the funds from this grant, the MS Division of Medicaid conducted a feasibility study to determine the potential costs and cost savings expected by developing a waiver for this population. In conducting the feasibility study, for families of children with high intensity needs were included, so that their needs will be heard and addressed in the development of services. The total budget for the planning grant application was \$99,000, which was used over an approximately two-year period. The first priority was to include families of children with special needs in the process; 20% of the grant funds will be used to hold public meetings and provide assistance to family members in attending those meetings to provide their valuable insight at forums facilitated by Mississippi Families As Allies for Children's Mental Health (MS FAA). As part of the project's planning phase, beginning in May 2005, MS FAA managed logistics for a series of focus groups held in seven regions in May, June and July 2005 to gather information from parents, foster parents and caregivers on gaps and needs in the community-based treatment/service system. The remaining 80% of the grant funds were used to employ consultants with Vanderbilt University to conduct the feasibility study, to determine a case rate for services, and to develop the implementation and evaluation plan.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for a Community-based Alternatives 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 will assist 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 will be 1970. Programs approved for funding under this demonstration grant will include 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and wrap around teams that will develop individual service plans. Mississippi Medicaid's resulting research data will be evaluated for cost effectiveness, quality of treatment, and outcomes for the children involved. The CA-PRTF demonstration grant, which will be administered by the Mental Health Programs Bureau, Division of Special Mental Health Initiatives within the Division of Medicaid, will only operate as a waiver and will compare cost of PRTF care to the cost of the waiver. The amount of the grant, which is \$49 million, is to be dispersed over a five-year period and can only be used for the expenses incurred by this waiver program. 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 SED, a reduction in the overall cost to the State, and an improved system of care for youth with SED.

Mental Health Services

Mental Health Transformation Activity: Suicide Prevention/ Early Mental Health Screening, Assessment and Referral (NFC Goal 1.1 and Goal 4)

Youth Suicide Prevention

The MS Youth Suicide Prevention Council has met at least quarterly since its creation in late 2006. The MS Youth Suicide Prevention Council's role includes providing 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. Representatives on the state level council are from the Mississippi Department of Education, the Mississippi 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, Division of Children and Youth Services and Division of Disaster Preparedness and Response. In FY 2008, the MS Youth Suicide Prevention Council coordinated the first annual Youth Suicide Prevention Conference, which included workshops on The Role of the Church in Suicide Prevention, Trauma and Suicide, Surviving After a Suicide in the Family, Prevention of Suicide in Schools and on College Campuses, and Risk Factors. In September 2009, a Youth Suicide Prevention Pre-conference Workshop was provided in association with the Mississippi Alliance for School Health Annual Conference. By March 2010, two presentations at workshops/seminars were provided, two safe TALK trainings were conducted and two have been scheduled for June. An ASIST training is scheduled for September.

Goal: To facilitate statewide development and implementation of Youth Suicide Prevention and Intervention Strategies

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

Indicator: Number of trainings or workshops related to youth suicide prevention.

Measure: The number of trainings and presentations at workshops/seminars by staff on suicide prevention

Mental Health Transformation Indicator: Data Table C1.2	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Number of suicide awareness, prevention sessions/workshops	Not an objective in Plan (project initiated)	9 districts (in six coastal counties); 14 districts and 3 additional	1 ASIST Training, 6 safe TALK presentations at workshop/seminars	1 ASIST Training, 4 safeTALK,	Four presentations

		schools (with special accreditation) in counties in other parts of state (outside coastal counties)		presentations at workshop/seminars	at workshops and seminars
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Strategy: Several DMH staff, as well as other staff from nonprofit service providers participating on the Youth Suicide Prevention Advisory Council have been trained in ASIST and safeTALK. These staff conduct training upon request by mental health centers, universities, community colleges and other community agencies. Other members of the Youth Suicide Prevention and Advisory Council are available to conduct workshops and presentations on youth suicide prevention and awareness to community organizations, to other agencies, or at conferences, when requested.

Source of Information: Monthly Activity Reports Forms

Special Issues: None

Significance: According to Mississippi Department of Health statistics, in 2008, approximately 53 youth ages 15-24 completed suicide, making it the third leading cause of death in Mississippi for this age group.

Prevention/Early Identification and Intervention Services

Prevention programs provide services to vulnerable at-risk groups prior to the development of mental health problems. Children who are especially vulnerable include children in one-parent families, children of parents with mental illness, children of parents with alcohol abuse problems, children of teen parents, children with an incarcerated parent, children experiencing severe deprivation, children who have been abused or neglected, and children with physical and/or intellectual handicaps.

Early intervention programs, which often are designed to include collaboration among service programs, are intended to intervene at the earliest possible time with troubled youth. However, many of these youth who come to the attention of providers through early intervention programs are often found to have serious behavioral or emotional disorders requiring more intensive and perhaps multiple, special services. Existing early intervention mental health programs funded through the DMH target primarily youth who have been abused (sexually/physically/emotionally) and single teenage mothers.

In FY 2009, DMH continued to provide funding to three prevention programs. As of March 2009, Vicksburg Child Abuse Prevention Center (CAP) had served 104 children from 38 families, Family-and Vicksburg Family Development Center had served 130 children. As of January 2009, services funded by DMH at Family Support Center for Metro Jackson were suspended. The Division of Children and Youth Services does not anticipate funding this third program in FY 2010. Prevention services supported through state funds from DMH and provided to these families include home visits, prenatal education, parenting education classes, preschool classes, and sibling intervention groups. With DMH state funds, the Exchange Club of Vicksburg CAP Center provides a Parent Aide Program to families with child abuse/neglect programs. This program includes home visits, case management services, instructional activities, information and referral services, support services, parent education classes, and follow-up. DMH continued to fund Pine Belt Mental Healthcare Resources and the Vicksburg Family Development Services for specialized multidisciplinary sexual abuse prevention programs at the beginning of FY 2009. Due to a decrease in the final FY 2009 CMHS Block Grant award, funding for the specialized program operated by Pine Belt Mental Healthcare Resources could not be renewed after March 2009. As of March 2009, Vicksburg Family Development Service had served 88 children from 54 families and Pine Belt Mental Healthcare resources had served 54 children from 54 families, for a total of 142 children served. By March 2010, DMH continued to provide funding to two prevention programs: Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center.

The DMH also participates in statewide child abuse prevention efforts by having a representative on the State Board for the Children's Trust Fund. This fund is drawn from \$1.00 fees on each birth certificate and other donations. These funds support projects across the state and provide 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.

Goal: To further develop and/or enhance the prevention/specialized early intervention service components of the Ideal Service System Model for children with serious emotional disturbance.

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Prevention/specialized early intervention programs funded.

Indicator: The number of programs to which DMH makes available funding to help support prevention/early intervention.

Measure: Count of programs to which DMH makes available funding for mental health prevention/early intervention activities. (Two programs that serve families of children/youth at-risk for or with SED, including teen parents.)

PI Data Table C1.2	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Prevention/Early Intervention–Funded Program	3 programs funded; 428 children served	3 programs funded; 1105 children served	3 programs funded	2 programs funded	2 programs funded

Source(s) of Information: DMH RFPs/grant applications/grants.

Special Issues: None

Significance: These programs provide specialized prevention/specialized early intervention services for targeted at-risk groups, including teen parents. One of these specialized programs collaborates with local agencies in the community and with local MAP Teams to further enhance and develop wraparound services for children who have experienced sexual abuse. The program participates on a local multidisciplinary task force that has increased interaction with other professionals in local child service agencies. Children/youth with SED who are identified by this program 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.

Funding: State and local funds, and CMHS Block Grant and other grant funds as available

In FY 2009 eight CMHCs and Catholic Charities had 74 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts had been provided to eight CMHC regions (4,6, 8, 9,10, 12, 14,and 15) pertaining to children’s mental health services for children with SED under the age of six years. By March 2010 there were 75 specialized day treatment programs for children ages 3-5 years. Technical assistance had been provided to regions 6, 9, and 10.

Objective: 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.

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Early intervention technical assistance

Indicator: 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.

Measure: Contacts by DMH Division of Children and Youth Services staff with providers to make available technical assistance on developing mental health services for children under six years of age will be documented.

Source(s) of

Information: DMH Division of Children and Youth Services monthly staffing report forms.

Special

Issues: None

Significance: The DMH Division of Children and Youth Services encourages and supports programs that include services to identify and intervene with children under the age of six with a serious emotional disturbance including those children who screen positive for prenatal exposure to alcohol to identify problems and intervene as early as possible.

Funding: Federal, state, and local

Diagnosis and Evaluation Services focusing on assessment of primary needs of children suspected of having an emotional or mental disorder continued to be available through the 15 regional community mental health centers. Revised minimum standards (effective July 1, 2002) that describe specific criteria and documentation requirements for an eligibility determination of serious emotional disturbance include use of a functional assessment instrument/approach approved by the Department of Mental Health. More comprehensive, multi-disciplinary assessment services are available through the public school system, Headstart, the University of MS Medical Center Child Development Clinic, (UMMC Department of Psychiatry and Human Behavior), and private facilities/practitioners. The UMMC Pediatric Child Development Center is the fetal alcohol spectrum disorders (FASD) assessment center in Mississippi and collaborates with the DMH Division of Children and Youth Services and the State FASD Coordinator. Also, the DMH Division of Children and Youth Services collaborated with the MS Department of Human Services (DHS) Division of Youth Services in use of the Massachusetts Youth Screening Instrument, version 2 (MAYSI-2) to screen youth in the juvenile detention centers for potential mental health service needs. Through the 1991 Expanded Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) process that includes assessment and treatment for mental health, initial screening, followed by more comprehensive, multidisciplinary diagnosis and evaluation will continue. The diagnosis and evaluation component through this process is being provided primarily by private providers reimbursed through Medicaid.

While revising the current DMH Minimum Standards, (2002 edition) Division of Children & Youth staff and Children's Services Coordinators from local mental health agencies are reviewing the potential use of standardized screening and assessments for children with serious emotional

disturbance.

Mental Health Transformation Activity: Individual Treatment/Service Planning (NFC Goal 2.2)

The DMH Division of Children/Youth Services continues to monitor community mental health service providers' compliance with established minimum standards for development of individualized treatment plans for children with serious emotional disturbance.

Day Treatment is a therapeutic service designed for individuals who require less than twenty-four (24) hour-a-day care, but more than other, less intensive outpatient care. Intensity and duration of the child's/youth's problem(s) are key factors in determining the need for day treatment. In FY 2009, technical assistance was provided to all 15 CMHCs for development and certification of new day treatment programs.

Mental Health Transformation Activity: Supporting School-based Mental Health Programs (NFC Goal 4.2)

School-based Day Treatment will continue to be available in FY 2009, and the Division of Children and Youth Services will provide technical assistance to school-based day treatment sites as needed. During FY 2008, CMHCs reported a total of 312 day treatment programs, with 50 center-based programs and 262 school-based programs.

Outpatient Services, which include individual, group and family therapy, will continue to be available through the 15 CMHCs and some other nonprofit programs. In FY 2009, a total of 26,348 children with serious emotional disturbance were reported as having received outpatient services through the 15 community mental health centers, including individual, group, or family therapy services.

Mental Health Transformation Activity: Supporting School-based Mental Health Programs (NFC Goal 4.2)

School-Based General Outpatient Services

Current *DMH Minimum 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.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of school-based general outpatient services

Indicator: Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families.

Measure: 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).

PI Data Table C1.6	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Availability of School- based Outpatient Services (Offered to schools)	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions; 662 school-based outpatient sites (FY data spans two school years).	Offered by 15 CMHC Regions; 715 school-based sites (FY data spans two school years).	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions

Source(s) of

Information: DMH Division of Children and Youth Services records/reporting; Annual State Plan Survey

Special

Issues: *DMH Minimum Standards for Community Mental Health/Mental Retardation Services*, effective July 1, 2002, require that CMHCs offer school-based outpatient therapy to each school district in their region or provide documentation of refusal of the service by the district.

Significance: The DMH Minimum Standards require that each CMHC offer school-based outpatient therapy to each school district in their region.

Funding: State and federal funds

Mental Health Transformation Activity: Supporting School-based Mental Health Programs (NFC Goal 4.2)

Therapeutic Nursing Services

Nurses provide therapeutic health interventions that are directly related to mental health. In FY 2009, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools and made 16,707 contacts, which included services such as providing education for children/youth with SED, their families and teachers, conducting physical observations and assessments, monitoring medications, and monitoring sleeping habits. Region 8 nurses had provided 26,202 contacts, which included nursing assessments, medication monitoring, and physical observations

for these children receiving outpatient services through Region 8 CMHC. By March 2010, Region 4 nurses made 10,385 contacts and Region 8 nurses made 20,319 contacts.

Objective: 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.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of funding for therapeutic nursing services.

Indicator: Availability of funding to targeted community mental health regions to provide ongoing therapeutic nursing services to children with SED.

Measure: The number of regions to which DMH will provide funding for intensive therapeutic nursing services for children with serious emotional disturbances.

PI Data Table C1.8	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Regions w/ DMH Funding for Intensive Therapeutic Nursing Programs	2 regions funded				

Source(s) of Information: Therapeutic nursing monthly summary form

Special Issues: Designated Division of Children and Youth staff continues 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. Additional data tracked through these projects include the total number of children served, and, in the rural area project, the number of contacts with children, and further, in the rural/urban area project, the number of hours of service.

Significance: The registered nurses will be available to provide mental health nursing services to children with SED, such as information about medications, physical observations/assessments, monitoring of behavior, eating and sleeping habits, assistance with health objectives on treatment plans, etc.

Funding: Federal funds

Respite Services 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. Ideally, respite services may be provided in-home or out-of-home by trained respite workers or counselors, as community-based residential or nonresidential services. Mississippi Families As Allies for Children’s Mental Health, Inc. (MS FAA) provides respite services and is the administrator for training for respite program. In FY 2009, Mississippi Families As Allies for Children’s Mental Health, Inc. had provided training to 43 respite providers and reported serving 140 youth. MS FAA reported 62 respite providers statewide. Harden House had provided respite training to 66 respite providers and reported serving 272 youth. Harden House reported 177 respite providers available statewide. By March 2010, MS FAA provided training to 43 respite providers (20 of which were new) and reported serving 80 youth. Of the 43 respite providers, MS FAA reported 26 providers available statewide. DMH also continued to provide funding to Harden House for respite. Harden House provided training to 193 providers (16 of which were new) and reported serving 121 youth as of March 30, 2010. Harden House reported 193 respite providers statewide.

Goal: To develop the respite services component of the Ideal System Model for children with serious emotional disturbance.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Respite program funded

Indicator: Continuation of funding from DMH to support the implementation of respite services.

Measure: Number of respite providers available during the year (100)

PI Data Table C1.9	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# New Respite Providers Trained	20 respite providers trained by MS FAA, including five new providers; Harden House trained 52 respite providers	22 respite providers trained by MS FAA; Harden House trained 64 respite providers; all providers trained were new.			

# Respite Providers Available			50	75	100
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Source(s) of Information: Annual State Plan Survey

Special Issues: None

Significance: 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. The need for this service and for training of providers because of attrition is ongoing.

Funding: CMHS block grant, state, and local funds, federal, and/or other grants as available

Housing

Community-Based Residential Treatment Services

Mental Health Transformation Activity: Support of Evidence-Based Practices (NFC Goal 5.2)

Therapeutic Foster Care (TFC) Services continue to be an important community-based component of the Ideal System Model, 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. TFC provides the child with the special attention he/she needs to adapt to a completely different home environment. The major barrier in expanding these homes is the difficulty in finding families to serve the increasingly difficult-to-serve children who need foster care. These children include, but are not limited to, children/youth who demonstrate severe emotional/mental disorders, may have sexually reactive disorders, oppositional-defiant disorders, conduct disorders, may be delusional, and/or, at times, may be suicidal.

As of March 2009, DMH continued to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. In FY 2009, DMH Division of Children and Youth staff continued to make available technical assistance to existing therapeutic foster care programs and/or to other programs seeking DMH certification to support provision of therapeutic foster care services that meet DMH Minimum Standards.

Goal: To further develop the community-based residential mental health treatment components of the Ideal Service System Model for Children with Serious Emotional Disturbance.

Target: To continue to provide DMH funding to assist in providing therapeutic foster care homes to serve children/youth with SED.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Indicator: Number of children receiving therapeutic foster care services through a certified program receiving funding from DMH.

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

Sources of

Information: Division of Children/Youth Services Program grant reports

Special

Issues: In accordance with federal URS table reporting instructions, includes only those children served in programs receiving funding support from the public mental health agency are included in the table below. Additional youth were served in therapeutic foster care funded by other agencies, including the Department of Human Services; 214 children/youth with serious emotional disturbances received therapeutic foster care services in FY 2008; 27 received services in therapeutic foster care homes operated by Catholic Charities, with partial funding support from the Department of Mental Health. This data is based on the state definition of therapeutic foster care in the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services*, which is consistent with CMHS minimum reporting requirement guidelines for this evidence-based practice. DMH is continuing work to develop capacity for collection of information for the core indicators on evidence-based practices, such as therapeutic foster care services. It should be noted that therapeutic foster care is primarily funded by the MS Department of Human Services (DHS).

Significance: Therapeutic foster care is an important component of the system of care, to provide a home setting for some children with serious emotional disturbance, who otherwise might not have adequate parental guidance/support.

Action Plan: 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. In FY 2009, visits to provide technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages in Jackson, Methodist Children's Ministries, Mississippi Children's Home Services in Jackson and on the Gulf Coast., Stepping Stones, Catholic Charities, and Harden House.

As of May 2010, technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages and Mississippi Children's Home Services.

National Outcome Measure: Evidence-based Practice – Therapeutic Foster Care (URS Developmental Table 16)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
Percentage of children with SED served who received therapeutic foster care services*	.08	.09	.11	.08	.07
Numerator: Number Receiving Therapeutic Foster Care Services*	24	27*	23*	23	22
Denominator: Number of children with SED served by the state mental health agency (community services)	28,939	29,269	21,000	28,500	28,500

*See Special Issues section, before performance indicator table.

Interagency Collaboration in Provision of Foster Care Services

The Department of Human Services (DHS), Division of Family and Children's Services, in addition to DHS internal processes, has continued to encourage social workers and other appropriate staff in the counties having one of the existing Making A Plan (MAP) teams to present cases to these teams of any child/youth in DHS custody for whom therapeutic placement was being considered. It is expected that through these MAP team reviews, needed mental health services through the CMHCs will be provided to an increased number of foster children who previously did not come to the attention of the local CMHC. Through the delivery of such services, as well as any other service that may be accessible through other MAP team agencies or

other representatives/stakeholders, it is likely that the regular foster care homes for these children can become more therapeutic in nature. Some children may be able to leave the foster care system and return to live with their families with the support of the MAP Team services. The MS Department of Human Services, Division of Family and Children’s Services continues to collaborate with DMH to find ways to expand and better utilize the MAP teams.

Therapeutic Group Homes are another major community-based residential service component of the ideal system of care. The primary mission of therapeutic group homes is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in therapeutic group homes are individuals who need intensive treatment in a community-based residential setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a therapeutic group home is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Therapeutic group homes funded

Indicator: Continued availability of funding from DMH to support therapeutic group homes

Measure: Number of therapeutic group homes for which the DMH provides funding support (nine)

PI Data Table C1.11	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Funded Therapeutic Group Homes	Funding allocated for support of 13 homes, which served 237 children. An additional 129 youth served through homes certified, but not funded by	Funding for support of 12 homes was allocated, but one of the homes was not yet opened at the end of FY 2008; 209 children served through	Funding for support of 9 homes was allocated; 219 children served through homes with DMH funding support; An additional 257 youth served	Nine	Nine

	DMH.	homes with DMH funding support; An additional 201 youth served through homes certified, but not funded by DMH	through homes certified, but not funded by DMH		
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Source(s) of

Information: Division of Children/Youth Services Residential Monthly Summary Forms/Grant Proposals from the existing DMH-funded therapeutic group home providers.

Special

Issues: In FY 2010, DMH certified twelve therapeutic group homes that did not receive DMH funding. The Department of Human Services provided funding for these homes and continues to require DMH certification, since they are therapeutic in nature.

Significance: Therapeutic group homes are a needed option in the comprehensive array of services for children with serious emotional disturbances.

Funding: CMHS Block Grant, state, and local funds. Additional funding may be available from foundation funds or other private sources, the Department of Human Services (for those children/youth in DHS custody), and/or the State Department of Education.

Other Housing Services

Housing assistance is available through federal housing programs, administered through local housing authorities, and through some social services programs administered through the Department of Human Services. In addition to the therapeutic community-based residential programs described previously in this section, examples of housing assistance reported as accessed by individual community mental health children's service providers in FY 2009 included: federal housing assistance (subsidized housing/rental assistance/Section 8/Shelter Plus Care) through local housing authorities; respite/emergency housing, shelter for victims of domestic violence, permanent housing, skills training and counseling/case management to teach clients to rent or purchase housing and maintain a household, financial assistance for utilities, assistance with building and refurbishing homes, winterizing assistance, assistance with housing applications, mortgage counseling, and appliance purchase. In addition to local housing authorities, examples of other organizations assisting with housing included HOPE Credit Union, Habitat for Humanity, local MAP teams, Transitional Outreach Programs, the Salvation Army, PRVO, and local faith-based organizations.

National Outcome Measure: Increased Stability in Housing (URS Table 15); Percent of Youth Reported to be Homeless/in Shelters

- Goal:** To continue support and funding for existing programs serving children who are homeless/potentially homeless due to domestic violence or abuse /neglect.
- Target:** To continue support and/or funding for an outreach coordinator and intensive crisis intervention services to youth/families served through these programs.
- Population:** Children with serious emotional disturbance
- Criterion:** Comprehensive, community-based mental health system
- Indicator:** Number of youth served in the public community mental health system, reported as homeless/in shelters
- Measure:** Number of youth reported as homeless/in shelters as a percentage of youth served in the public community mental health system

Sources of

Information: Division of Children/Youth Services Program grant reports and DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile

Special

Issues: According to Uniform Reporting System Guidelines for Table 15 (Living Situation), the number of children who are homeless/in shelters within all DMH-certified and funded community mental health programs are reported, including two programs that are specialized as they provide outreach and/or a safe place for homeless women and their children and homeless children who have been removed from their homes due to abuse/neglect. Therefore, the percentage of youth who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of children served by these specialized programs occur. DMH is continuing work to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and ongoing efforts to improve data integrity might result in adjustments to baseline data.

Significance: Specialized services for homeless women and their children and/or homeless children/adolescents provide needed outreach and mental health services, along with supports to address the shelter and housing needs of the families served.

Action Plan: DMH will continue to provide funding and support for **two** specialized programs serving homeless children/youth with SED, described in separate objectives under Criterion 4 in the State Plan. Gulf Coast Women's Center for Nonviolence provides shelter for children and their mothers who are experiencing violence at home. Through Gulf Coast Mental Health Center, a therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the local shelter. The local shelter services children who have allegedly experienced abuse and/or neglect

DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Performance Indicator					
% of youth reported homeless/in shelters	.2%	.25%	.2%	.26%	.2%
Numerator: # youth reported homeless/in shelters by DMH certified/funded providers	63	78	63	80	81
Denominator: # All youth reported with living situations by DMH certified/funded providers, excluding Living Situation Not Available	29,622	31,099	29,622	29,955	30,825

Educational Services

Children with serious emotional disturbance who meet eligibility criteria in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. Additional information on services provided by local systems under the Individuals with Disabilities Education Act of (2004) is described under Criterion #3 that follows.

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. One community residential program for youth with substance abuse problems, The ARK, in Jackson, MS provides a State Department of Education accredited special school on campus. Two approved Department of Education teacher units are provided at Sunflower Landing, another community residential program for adolescents with substance abuse problems. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. See Criteria #3 for additional information on interagency collaboration.

National Outcome Measure: Return to/Stay in School (URS Table 19B): See Criterion #3.

Services to Special Populations

Mental Health Transformation Activity: Support for Services for Youth with Co-occurring Disorders (Mental Illness and Substance Abuse) (NFG 5.2)

As recommended by the Children's Services Task Force of the MS State Mental Health Planning and Advisory Council, the Department of Mental Health began to explore strategies for increasing efforts to address the needs of youth with co-occurring disorders. For example, the Alcohol and Drug Studies School included sessions pertinent to co-occurring disorders for youth. Three community-based residential programs funded by DMH for adolescents with substance abuse problems also address problems of youth with co-occurring disorders. Division of Children and Youth staff continues to monitor and provide technical assistance to these three programs. Beginning in FY 2009, the FASD Coordinator will provide 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.

The DMH has pursued initiatives to improve services in this area for many years; most of those efforts were coordinated by what was formerly the Dual Diagnosis Task Force, which was restructured to become the Co-occurring Disorders Coordinating Committee. The group has functioned to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse and sponsored 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.

In the Spring of 2006, COCE facilitated a draft Strategic Plan for Co-occurring Disorders developed in a two and a half-day intensive planning session by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded.

The Co-occurring Disorders Coordinating Committee was reconvened in FY 2007 to review, refine and address objectives in the plan. Representatives of the Division of Children/Youth Services now 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 and the Division of Policy and Planning. Plans are to expand the membership to include additional individuals receiving services and family members.

In June 2005, the DMH Division of Children and Youth Services employed a full-time FASD project director and co-sponsored an FASD Symposium for professionals and families. In April 2007, the FASD Project Director was designated as the State FASD Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS AC-FASD). An FASD contract with Northrop Grumman was initiated in February 2008 to work through the CMHCs and the MAP Teams statewide to screen, diagnose and treat children with FASD.

As of March 2009, the Director of the Prevention Unit in the Bureau of Alcohol and Drug Abuse had been seated on the FASD Task Force. Division of Children and Youth Services staff participated in the 3rd Annual School for Addiction Professionals and provided FASD information for the attendees. 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. The Children and Youth Services staff member continues to serve on the planning committee for the MS School for Addiction Professionals. Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK, Sunflower Landing and the CART House, which serve youth with co-occurring disorders.

Goal: To further the identification and provision of appropriate services to special difficult-to-serve populations.

Objective: To further develop the linkage between the Division of Children and Youth and the Bureau of Alcohol and Drug Abuse regarding issues of children/youth with SED, FASD, and substance abuse problems.

Population: Children with serious emotional disturbance or at risk for emotional illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Collaboration between children/youth behavioral health and alcohol/drug abuse

services.

Indicator: Collaboration between the Division of Children & Youth and Bureau of Alcohol & Drug staff in exchange of information, training opportunities, and participation in Task Forces and Committees.

Measure: Continuation of the participation of children & youth services staff on related Bureau of Alcohol and Drug Services Task Forces, Committees, and activities that targets services to youth; tracking of the number of technical assistance and certification visits by DMH staff to programs implementing and/or planning programs to serve youth with a dual diagnosis of substance abuse and emotional disturbance; and tracking the number of children screened for FASD by the CMHCs.

Source(s) of

Information: DMH Division of Children/Youth Services monthly staff forms

Special

Issues: Division of Children and Youth Services staff members continue to collaborate with the Division of Alcohol and Drug Abuse. Division of Children and Youth works with Division of Alcohol and Drug Abuse staff to monitor and provide technical assistance to three DMH-funded residential programs that include some children/youth with co-occurring disorders

Significance: The DMH Director of the Division of Children and Youth Services and the Director of the Division of Alcohol and Drug Abuse collaborate closely to improve and further develop the options for children/youth with SED and substance abuse to be included in the system of care. Also, a staff member in the Division of Children and Youth participates on the Co-occurring Disorders Coordinating Committee, and a staff member of the Division of Alcohol and Drug Abuse participates on the Children's Services Task Force of the State Mental Health Planning and Advisory Council. Staff from both divisions are members of Mississippians Allied Against Underage Drinking (MAAUD), the statewide underage drinking taskforce.

Funding: Federal and state

As of April 2010, 2003 children ages 0 – 7 years had been screened for Fetal Alcohol Spectrum Disorders (FASD). Of this number, 186 were identified as needing a full diagnostic evaluation at the FASD diagnostic clinic at the University of Mississippi Medical Center (UMMC) to determine if they had FASD. To date, 23 children have been diagnosed with FASD.

Goal: To identify children/youth with Fetal Alcohol Spectrum Disorders (FASD) and identify services to meet individualized needs of these children.

Objective: To make available FASD screening assessments through the 15 CMHCs and the MAP Teams to identify children/youth that screen positive for possible FASD and

need to receive a diagnostic evaluation to determine if an FASD diagnosis is warranted.

Population: Children and youth with serious emotional disturbance or at risk for serious mental illness who are suspected to have an FASD.

Criterion: Comprehensive, community-based mental health system.

Brief Name: FASD screening availability

Indicator: The number of FASD screenings conducted by the CMHC and/or the MAP Team in which community service providers make available FASD screening in accordance with DMH minimum standards or which submit an acceptable Plan of Correction if not in compliance with standards

Measure: Count of the number of FASD screenings conducted each year in or through the CMHCs and the MAP Teams.

PI Data Table	FY 2008 (Estimate)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
FASD screenings conducted	Not an objective in the FY 2008 State Plan, but it is estimated that 1,848 screenings will be conducted	800	800	2000

Source(s) of

Information: DMH Division of Children and Youth Services monthly service report forms and MAP Team referral reports.

Special

Issues: The local MAP Team coordinators will be responsible for coordinating the FASD screening, helping refer children for diagnosis, ensuring inclusion in the child’s treatment plan, and coordination of provision of services.

Significance: The DMH Division of Children and Youth Services encourages and supports screening children with a serious emotional disturbance for possible fetal alcohol spectrum disorders in those cases where indicated in order to provide identification of problems and intervention as early as possible.

Funding: Federal, state and/or local funds

The DMH Bureau of Alcohol and Drug Abuse Services reorganized the statewide conference on co-occurring disorders in FY 2008 and included co-occurring disorders and issues pertaining to adolescents among the topics addressed at the state's first Alcohol and Drug Studies School. As of March 2009, a Children and Youth Services staff member was designated to continue participation on the Co-occurring Disorders Coordinating Committee. Additionally, 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, had held several workshops specifically addressing topics such as cognitive behavioral therapy techniques, strengths-based wraparound approaches, and implementation of the *Seven Challenges* program. The 3rd Annual Mississippi School for Addiction Professionals held January 2010, provided several sessions on youth with co-occurring disorders. Additionally the Annual Lookin' To The Future Conference to be held July 2010 will include a session on youth with co-occurring disorders.

Objective: The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned for FY 2010

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Collaboration between children/youth behavioral health and alcohol/drug abuse services.

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

Measure: The 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

Source(s) of Information: Conference program(s)

Special

Issues: 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

Significance: Provision of specialized training in dual disorders (mental health/substance abuse) among youth will facilitate identification and appropriate treatment in local programs.

Funding: Federal and state

Community-based Residential Treatment Programs for adolescents with substance abuse problems provide treatment services for youth who need intensive intervention. These programs have a schedule of activities that includes 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. In 2009, DMH continued to provide funding to three programs, which make available 56 beds for chemical dependence residential treatment for adolescents, some of whom also had a serious emotional disturbance. By March 2010, the three programs had served 66 adolescents with substance abuse problems or co-occurring disorders of substance abuse and SED in a community-based residential treatment. Sunflower Landing served 22 youth (22 of whom had co-occurring disorders), CART House served 26 youth (16 of whom had co-occurring disorders, and the ARK served 18 youth, (18 of whom had co-occurring disorders).

Objective: To provide funding to maintain 56 beds in community-based residential treatment services for adolescents with substance abuse problems.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of community substance abuse treatment program beds

Indicator: Availability of community-based residential treatment program services for adolescents with substance abuse problems provided through sites in FY 2011.

Measure: Number of beds available in community-based residential treatment programs for adolescents with substance abuse problems that receive funds from DMH (56).

PI Data Table C1.12	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Beds Funded Residential Treatment Program	56 beds available; 175 youth served	56 beds available; 146 youth served	56 beds available; 137 youth served	56 beds available	56 beds available

Source(s) of Information: Division of Children/Youth Services Residential Monthly Summary Form/Grant Proposals for three community-based residential treatment sites.

Special Issues: None

Significance: Adolescents who have co-occurring disorders (substance abuse/mental illness) will also continue to be accepted in these programs.

Funding: Federal funds

Youth with Co-occurring Disorders of Mental Illness and Intellectual/Developmental Disabilities

In FY 2009, three CMHCs provided school-based day treatment programs for children and youth with co-occurring disorders of mental illness and intellectual/developmental disabilities.

Mental Health Transformation Activities: Support for Culturally Competent Services (NFC Goal 2.2)

Multicultural Task Force

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the 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. The task force membership was expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling has also been helpful. There were 36 members on the task force during the development of the Cultural Competency Plan including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-Mississippi; Mental Health Association Director; Jackson State University, School of Social Work; Jackson State University, SMHART (Southern Institute for Mental Health Advocacy, Research and Training); Jackson-Hinds Community Health Center, Ellisville State School, Jackson Healthcare Center, Grant Consultant; and Chairperson of the Mississippi State Mental Health Planning and Advisory Council. Currently, there are 17 active members on the task force. The task force is developing a cultural competency plan and has completed the Multicultural Competency Task Force Strategic Map and action plan for several of the strategic initiatives. The Multicultural Competency Task Force Strategic Map mission statement 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.” The definition of cultural competency chosen by the task force members is: “the acceptance, understanding and embracing of all cultures.” “Culture” refers to an integrated pattern of human behaviors that includes language, thoughts, communications, actions, customs, beliefs, values and institutions of all individuals. The task force has developed the *Draft, Mississippi Department of Mental Health Proposed Plan for Cultural Competency*, and a subcommittee met to develop the

Communication Continuum for Sharing the Cultural Competency State Plan. By April 2010, the Multicultural Task Force had organized the annual statewide Day of Diversity (October 13, 2009) and held a meeting on November 23, 2009, and April 16, 2010. The annual report to the MS State Mental Health Planning and Advisory Council was presented by the Co-chairperson of the task force on April 22, 2010. .

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Multicultural Task Force operation

Indicator: Continued meetings/activity by the Multicultural Task Force.

Measure: The number of meetings of the Multicultural Task Force during FY 2010 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council.

Source(s) of

Information: Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made.

Special

Issues: None

Significance: 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.

Funding: State funds

Cultural Competency Plan

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation Cultural Competency Workgroup

Indicator: Meeting/activity by the Cultural Competency Workgroup

Measure: The development of the committee and number of meetings

Source(s) of Information: Minutes of the workgroup meetings

Special Issues: None

Significance: The function of the workgroup is to guide the implementation of the Cultural Competency Plan.

Funding: State Funds

Local Provider Cultural Competence Assessment

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. In FY 2009, Region 11 had received their local cultural competency assessment results and technical assistance in May 2009. By August 2010, Region 2 will complete the local cultural competency assessment. Results will be discussed with the region in by September 30, 2010.

Objective: 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.

Population: Children with Serious Emotional Disturbances

Criterion: Comprehensive, community-based mental health system.

Brief Name: Cultural competency pilot project expansion

Indicator: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project.

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

Source(s) of**Information:** DMH Activity Reports**Issues:** Participation in the project will be voluntary.**Significance:** 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.**Funding:** State and local funds**Mental Health Transformation Activities: Support for Culturally Competent Services and Workforce Development (NFC Goal 3.1)**

The Multicultural Task Force, which includes a representative of the Division of Children and Youth Services, continued to meet in FY 2009 to identify priority areas to be addressed related to cultural issues in community mental health service delivery. In FY 2010, the MCTF became advisory to the Mississippi Transitional Outreach Program (MTO) targeting transition-aged youth and further described under Criterion 3. Children and youth service providers had the opportunity to participate in their local CMHC Day of diversity activities in October 2008. In FY 2009, The 20th Annual Lookin' to the Future Conference and the Mississippi Conference on Child Welfare offered one session on cultural diversity that addressed issues of a "future with changing faces." The DMH continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model; Four NCBI training sessions were conducted in Region 1, 3, Region 8 (Copiah County, Rankin County and Simpson County) and MS FAA in 2009. By April 2010, an NCBI training session was conducted with 60 individuals at MS FAA. Local CMHC Day of Diversity activities were offered, and children and youth service providers were encouraged to participate. Staff of the Division of Children and Youth Services presented information on cultural competency at the 2009 Mississippi Black Leadership Summit: "Expanding Our Ranks Unleashing Our Power." Members have attended workshops on Disparities Among Native Americans, Resources for Spanish-Speaking Communities, National Networks of Libraries of Medicine, and Eliminating Mental Health Disparities: Challenges and Opportunities.

Goal: To further enhance service development and quality of service delivery to minority populations of children and youth with severe behavioral and emotional disorders.**Objective:** To address cultural diversity awareness and sensitivity through training sessions or workshops focused on this topic.**Population:** Children with serious emotional disturbance**Criterion:** Comprehensive, community-based mental health system**Brief Name:** Cultural diversity training**Indicator:** Number of training sessions presented for children/youth service providers that

address cultural diversity awareness and/or sensitivity.

Measure: Count of cultural diversity training sessions presented for children/youth service providers.

Source(s) of

Information: DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.

Special

Issues: None

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

Funding: Local, state, and federal funds

The DMH *Minimum 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. The DMH Division of Children and Youth Services continues to require additional assurances from providers with which it contracts that training addressing cultural diversity and/or sensitivity will be provided.

Mental Health Transformation Activity: Improving Access to Employment

Rehabilitation and Employment 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). (Current chairpersons are from the Mississippi Department of Mental Health.)

Specific examples reported of vocational/employment services accessed for youth by individual children's community mental health service providers in FY 2009 included: 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 were 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, Allied Enterprises, Recruitment/Training Program of Mississippi, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, Ability Works 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.

Substance Abuse Services

Community mental health centers are the primary providers for both community mental health and outpatient substance abuse treatment for youth. As described further under Criterion #3, the Bureau of Alcohol and Drug Abuse (BADA) and the Bureau of Community Services have increased collaborative efforts to better address the needs of youth with dual diagnosis of mental illness and substance abuse. The existing substance abuse prevention and treatment system components administered by the DMH Bureau of Alcohol and Drug Abuse that address the needs of youth are described below:

Substance Abuse Prevention Services: DMH Bureau of Alcohol and Drug Abuse continues to provide funding to support prevention activities, statewide, ensuring all 82 counties are provided prevention services. Primary prevention services are provided through 15 community mental health/mental retardation centers and 13 other community-based private/public nonprofit free-standing organizations.

It is the goal of BADA to decrease problems associated with alcohol, tobacco and other drug (ATOD) use and abuse by services which include prevention, intervention, and treatment services. In Mississippi, funds are provided to programs through the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The required 20% prevention set aside is only used for primary prevention. Primary Prevention services focus on individuals or populations before the onset of harmful involvement with alcohol or drugs. In addition, prevention services provide for persons who use drugs in a non-abusive way and are not in need of treatment for drug abuse or dependency. The DMH Bureau of Alcohol and Drug Abuse continues to develop and maintain programs that practice professional prevention activities carried out in an intentional, comprehensive, and systematic way, in order to impact large numbers of people, based on the

identified risk and protective factors. Programs funded by the 20% set aside are currently charged with developing specialized programs and initiatives targeting adolescent and young adult marijuana use, methamphetamine use, prescription drug abuse, and underage drinking.

In March 2006, BADA was awarded funds by the CSAP for a State Epidemiological Outcomes Workgroup (SEOW). In October 2006 this grant was incorporated into the newly awarded Strategic Prevention Framework State Incentive Grant (SPF SIG) (see next paragraph). The goal of the SEOW is to collaborate with other state entities to determine the scope and magnitude of substance abuse and associated problems in our state. The SEOW has two primary missions: use data to enable the state to successfully report on all National Outcome Measures, and create epidemiological profiles for all substances to include profiles of need, patterns of consumption, and consequences of substance use. Each of the profiles consists of consumption patterns of the State at large, as well as prevalence trends in race, gender and lifespan. Mississippi's substance abuse prevalence rate is examined and compared to national data. As a result of collaboration with the Mississippi Department of Education, a website was created to provide data related to Mississippi's youth and their risk and protective factors. (See www.snapshots.ms.gov)

In October 2006, the MS Department of Mental Health was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The SPF SIG assists the Bureau in its endeavor to implement a comprehensive substance abuse prevention system that enhances our ability to plan, implement, monitor, and sustain effective prevention practices. Approximately 20 subgrants will be awarded October 1, 2008, to community-based organizations. The priority of the SPFSIG is to reduce alcohol use and related consequences to include alcohol-related motor vehicle crashes, binge drinking and drinking and driving among youth between the ages of 11 and 21. Successful applicants will implement evidence-based programs, policies, and practices that address this priority.

Tobacco prevention

The Bureau of Alcohol and Drug Abuse continues to assist the Office of the Attorney General to determine the annual rate of tobacco sales to Mississippi minors. Coordinated efforts continue with completing the regulatory requirements of the Synar Amendment and the Annual Synar Report. Mississippi has always been in compliance with negotiated federal Synar rates. The Bureau of Alcohol and Drug Abuse tobacco inspections began in June 2010, and were completed in approximately six weeks. The final result this year was a non-compliance rate of 3.8%, which is substantially below the 20% maximum allowable non-compliance rate. Rates of underage access to cigarette products in Mississippi have consistently been among the lowest in the country.

The Bureau of Alcohol and Drug Abuse funded tobacco prevention activities in all 15 community mental health centers and 13 free-standing prevention programs whose stated objectives in the Block Grant application included emphasis on tobacco prevention efforts. The revised prevention RFP guidelines for FY 2006, FY 2007 and FY 2008 require all contractors to provide some DMH/BADA approved tobacco use prevention information/education activities. Each mental health region also conducts merchant education in their respected area. Each region is required to provide education to a minimum of 40 merchants.

Substance Abuse Services for Adults and Children

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 which address the needs of both adults and children are described below:

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided 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. In FY 2009, there were 6,184 individuals who received these services.

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. These services are provided by 11 community mental health centers, 11 certified free-standing programs and 1 adolescent program, CARES Center/the Ark. In FY 2009, there were 414 individuals who received these services.

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 continued to make available funding to one adolescent inpatient program, which is the Bradley Sanders Complex, an extension of East MS State Hospital, which served 83 youth in FY 2009.

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. These services are provided by 14 community mental health programs, 11 certified free-standing programs and three community-based treatment programs for adolescents programs. In FY 2009, there were 3,890 adults and adolescents who received these services; 137 adolescents were served in the three specialized programs.

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. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2009, there were 1,172 adults who received these services.

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. These services are provided by 14 community mental health centers, 21 certified free-standing programs and 1 adolescent program. In FY 2009, there were 4,339 individuals who received these services.

Referral Services: During FY 2009, the Bureau of Alcohol and Drug Abuse updated and distributed the current 2009-2010 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. During FY 2009, the Office of Constituency Services received and processed 731 calls requesting substance abuse information or assistance in finding treatment and/or other related/support services. Over 24 categories of “problems/needs” were addressed.

Employee Assistance Program: During FY 2009, the Employee Assistance Coordinator updated and distributed 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 continued to provide EAP trainings across the state.

Specialized/Support Services: These services include vocational rehabilitation 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. In FY 2009, vocational services were provided to 128 individuals. Other specialized/support services include providing treatment to individuals who have been diagnosed with a co-occurring disorder of mental illness and substance abuse. All 15 community mental health centers provide co-occurring services through SAPT block grant funds. The Bureau of Alcohol and Drug Abuse continued to provide funding to one of the state-operated psychiatric hospitals to manage a 12 bed group home for co-occurring individuals. In FY 2009, 11,419 individuals with a co-occurring disorder of mental illness and substance abuse were served. 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. At the close of FY 2009, there were 2,191 individuals who were eligible for DUI services and 1,711 inmates at the Mississippi State Penitentiary who were eligible for the residential alcohol and drug abuse treatment program.

Private Resources

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 52 licensed and/or Certificate of Need (CON) approved beds in FY 2009 for adolescents. 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.

Health/Medical and Dental Services

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. All children on Medicaid are eligible for Early Periodic Screening Diagnosis 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 Minimum 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.

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 157 delivery sites in Mississippi serving approximately 300,000 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 fluoride 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.

Mental Health Case Management Services

Target Population: 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 (defined as Medicaid);
- Children/youth with SED who are receiving intensive crisis intervention services; and,
- Children/youth referred to the CMHC after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks for referral for CMHC services).

Model of Case Management

Case Management within Mississippi's service system for children with serious emotional disturbance is key to access, linkage and coordination of services across the system of care (Stroul and Friedman, 1986). Case management facilitates delivery of and movement among all services in the Ideal System Model. Within a conceptual framework of interagency collaboration and cooperation, functions of local case managers include: assessment of needs and resources to address those needs; planning for individual children and families, including identification of

existing resources and/or constraints in implementing service plans; monitoring of progress of the child/family in relation to the service plan; linkage of services within and across child service agencies; facilitating access to services; and, addressing internal or external constraints on achieving goals/objectives of the service plan.

Outreach and Expansion of Case Management Services

Assessment of the need for case management for children and youth with SED who receive substantial public assistance will continue to be provided by regional community mental health centers. Documentation of evaluation of need for case management services by the target population of children and the offering of such services will be maintained. Those who demonstrate a need through this assessment will be offered case management.

Goal: To make available case management services to children with serious emotional disturbance and their families.

Objective: 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.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Provision of case management services

Indicator: Provision of evaluation services 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.

Measure: Number of children with serious emotional disturbances who receive case management services (14,000)

PI Data Table C1.14	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# SED Receiving Case Management	15,011	14,995	14, 666	13,000	14,000

Source(s) of

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

Special

Issues: The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG), to develop a central depository for data from the mental health system. As this system continues to be implemented, downward adjustments in targets are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

Significance: In accordance with federal law and the DMH Ideal System Model, children with serious emotional disturbance who are receiving substantial public assistance are a priority target population for mental health case management services.

Funding: Federal, State and/or local funds

See also objectives on Case Manager Training under Criterion #5.

The DMH *Minimum Standards for Community Mental Health/Mental Retardation Services* continue to require providers certified by DMH to establish and/or participate on a MAP Team. See objective under Criterion #3. Programs are also monitored on site visits to determine the utilization of a local MAP Team to serve children and youth with SED.

School Based Services (Consultation and Crisis Intervention), Mental Illness Management Services (MIMS) and Individual Therapeutic Support are case management services that became available for children with serious emotional disturbances in FY 2002.

School-Based Services are professional therapeutic services provided in a school setting that are more intensive than traditional case management services. School-based services include consultation and crisis intervention and must be provided by a Masters-level therapist/case manager.

Consultation is professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

Crisis Intervention is therapeutic engagement at a time of internal or external turmoil in a child's life, with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and/or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

In FY 2010, CMHC Regions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13 and 14 had been certified by DMH to provide school-based case management services.

Mental Illness Management Services (MIMS) include activities that may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the child/youth live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider of these services, required by the more complex mental health needs of some individuals with serious mental illness. In addition, individuals receiving MIMS must be evaluated at least every six months to determine the individual's readiness to resume traditional case management and/or other appropriate services. MIMS may be provided in any appropriate community setting by a staff member who holds at least a Master's degree (in an appropriately related field) and professional license (for example, as a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Master's level Social Worker or a physician) or who is a Department of Mental Health Certified Mental Health Therapist.

In FY 2010, Regions 1, 4, 5, 10, 13, and 15 were approved for the provision of MIMS for children and youth services.

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. The service may be provided in the youth's home, school or any other setting that is part of his/her environment. Individual therapeutic support focuses on the reduction/elimination of acute symptoms and is provided during a time when the youth is unable to participate in regular treatment activities, such as partial hospitalization or day treatment. This service must be provided by a staff member with at least a high school or equivalent degree who has completed certification approved by the Department of Mental Health. Regions 6 and 8 CMHCs are approved to provide individual therapeutic support services.

Activities To Reduce Hospitalization

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. An underlying purpose of the majority of the objectives in the State Plan is to prevent the need for and/or provide community-based alternatives to hospitalization and long-term residential or other out-of-home placement of children and adolescents, whenever possible. Since the initiation of the P.L. 99-660 planning process, efforts to expand/improve community-based mental health services for children and to foster and maintain interagency collaboration and coordination of services to respond to the multiple needs of children with severe disabilities in the community have been priorities of the Division of Children and Youth Services. Ongoing service expansion and interagency collaboration activities also reduce the risk of children being placed in out-of-home and/or out-of-state treatment settings.

Interagency collaboration activities, such as Making A Plan (MAP) Teams, seek to reduce the risk of children/youth being placed in out-of-home and/or out-of-state treatment settings. Specifically, MAP Teams work with children and young adults, up to age 21, who have a serious emotional disturbance and are at immediate risk for placement in an out-of-home treatment setting. MAP Teams work with children and their families to assess the strengths of the child and family in order to develop a comprehensive, individualized and strengths-based plan to meet the needs of

the child in his/her own home and community.

The State Level Review/MAP Team is another interagency collaboration activity designed to reduce the risk of children/youth being placed in out-of-home and/or out-of-state treatment. The State level Case Review/MAP Team reviews cases concerning children/young adults that have already been served by a local level MAP Team and for whom adequate services and supports cannot be found at the local levels. The State Level Case Review/MAP Team works with local MAP Teams to develop plans for children/young adults and their families that would also serve as an alternative to an out-of-home and/or out-of-state placement.

Pre-evaluation Screening and Civil Commitment Services, available through all 15 CMHCs, have as a major purpose to reduce the number of inappropriate admissions to the state psychiatric facilities and to ensure that community-based alternative services are available. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for commitment to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals (applies to youth age 14 years and over). The civil commitment process requires that the local CMHC conduct a pre-evaluation screening for the Chancery Court and the Youth Court to use to determine if the commitment process (including examination for inpatient or outpatient commitment) should continue. The pre-evaluation screener also provides useful information about available community services for the Court's consideration, if alternatives to inpatient commitment are appropriate. If the court determines there is a need to continue with the involuntary commitment process, the youth is evaluated by two physicians or by one licensed physician and one licensed and certified psychologist. The commitment examination may also be conducted by one licensed physician and a nurse practitioner or a physician's assistant who are independent from and not under the supervision of the other physician conducting the examination. The commitment examination is to determine if commitment should be made, either for inpatient or outpatient services.

The Department of Mental Health began making available training and certification to staff conducting pre-evaluation screening in April 1995. Implementation of a change in commitment law that requires single-point (CMHC) pre-evaluation screening of individuals being considered for civil commitment and subsequent training provided by DMH, facilitates coordination among the Courts, CMHC staff, and Court-appointed examiners throughout the referral, screening and examination process. It was also hoped that changes in the process will result in making the commitment process more standard (and thereby less difficult for consumers and families to navigate) across jurisdictions. In FY 2010, the DMH plans to continue training for community mental health center staff conducting pre-evaluation screening. Doing so facilitates a greater awareness of the system, communication, and coordination between the CMHC staff conducting the pre-evaluation screening and family members.

Acute Inpatient Services

Short-term, acute inpatient psychiatric services for adolescents with serious emotional disturbance are currently available statewide through two comprehensive state psychiatric hospitals (Mississippi State Hospital and East Mississippi State Hospital) and local public or private hospitals. Short-term public inpatient acute psychiatric services for children (statewide) are

provided by Mississippi State Hospital; short-term inpatient chemical dependence treatment for adolescent males (statewide) is provided at East Mississippi State Hospital. The goal of the state inpatient facilities is to make available quality inpatient services to children/adolescents in the state in need of this intensity of care, for whom these services are not otherwise available at the local, community level. In FY 2009, MS State Hospital operated a 10-bed unit for children and a 50-bed unit for adolescents in need of acute inpatient treatment. East MS State Hospital operated a 50-bed unit (located off the main adult campus) for adolescents in need of psychiatric or for adolescent males in need of substance abuse inpatient treatment. Both inpatient facilities provide education services through on-campus special school programs accredited by the Mississippi Department of Education. Admissions of youth to the state psychiatric facilities are governed by state statute and fall primarily into two categories: a) voluntary application for psychiatric services and substance abuse services; and b) involuntary admission by Chancery Court or Youth Court orders for psychiatric services or chemical dependence services.

Community-Based Emergency Response/Crisis Intervention

A major focus of state planning activities designed to reduce the rate of hospitalization of children with serious emotional disturbance has been on developing models for improving community-based response to emergencies and management of crises, with the aim of preventing the need for or providing alternatives to hospitalization in response to crises.

The major service components available through Hope Haven, a comprehensive crisis intervention program, include crisis intervention, child and family support, and outpatient services. Hope Haven also makes services available to youth who are homeless/runaway. A second model program funded by DMH and operated in Region 7, Community Counseling Services, serves seven counties (most of which are predominately rural) in the east-central part of the state. This program includes a crisis line specifically for children's services available across all seven counties, with linkages to other appropriate services. For children/youth in need of more specialized and intensive intervention, this CMHC focuses on two counties in which an array of specialized crisis services are made available through mobile crisis, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. Both comprehensive crisis programs utilize a 24-hour crisis hotline with mobile intensive intervention, enabling services to be provided quickly and efficiently at the youth's home. In FY 2000, Pine Belt Mental Healthcare Resources (Region 12 CMHC) began receiving state funds for operation of a third comprehensive crisis intervention/emergency response program. This program provides community-based crisis response services that are available on a 24-hour basis and an emergency on-call team both during and after work hours to act as a single point of entry into the program for two counties (Forrest and Jones) in the region. Additionally, since FY 2001 a fourth comprehensive crisis program, operated by Region 8 CMHC, has received DMH funding. As noted previously, Region 8 CMHC became a partner in the SAMHSA/CMHS Local System of Care grant project at the beginning of the fifth year of the six-year grant cycle, allowing for linkage to their model of crisis intervention services. In FY 2005, reallocated funding became available for development of a fifth comprehensive crisis service program in Region 4 (Timber Hills Mental Health Services, based in Corinth). Support for these five programs is planned for FY 2011.

Integration of Wraparound in Comprehensive Crisis Intervention Programs

All five non-profit providers of comprehensive crisis intervention programs are affiliated with their local Making a Plan (MAP) teams. The Department of Mental Health will continue to support expansion of crisis services for children, with the goal of establishing a statewide network of crisis management services.

- Goal:** To continue improvements in community-based emergency services/crisis intervention.
- Objective:** 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.
- Population:** Children with serious emotional disturbance
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Comprehensive crisis response models funded
- Indicator:** Continuation of DMH funding to implement comprehensive intensive crisis response programs for youth with serious emotional disturbance or behavioral disorders who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement.
- Measure:** Number of comprehensive crisis response programs for which DMH provides funding (5)

PI Data Table C1.16	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Funded Crisis Response Programs	5	5	5	5	5

Source(s) of

Information: Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for four comprehensive crisis response programs.

Special

Issues: None

Significance: These crisis programs provide a more comprehensive approach and service array to youth and families in crisis and will provide useful information in expanding

and enhancing crisis services in other areas of the state.

Funding: State and local funds, CMHS block grant, and Medicaid

In FY 2009, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects: Region 3 CMHC had served 227 youth; Region 13 had served 301 youth; Region 15 had served 45 youth; Gulf Coast Women's Center had served 44 youth; and, Mississippi Families As Allies for Children's Mental Health, Inc. had served 283 youth. By March 2010, Region 3 CMHC had served 100 youth; Region 13 had served 194 youth; Region 15 had served 67 youth; Gulf Coast Women's Center had served 70 youth; and, Mississippi Families As Allies for Children's Mental Health, Inc. had served 130 youth.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Intensive crisis intervention projects funded

Indicator: Continued funding by DMH for specialized outpatient intensive crisis projects (5)

Measure: The number of programs that receive DMH funding for specialized outpatient intensive crisis intervention projects. (5)

PI Data Table C1.17	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Funded Intensive Crisis Intervention Projects	5	5	5	5	5

Source(s) of

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

Special

Issues: None

Significance: These specialized local programs facilitate the provision of more comprehensive crisis services that are designed to meet unique needs of children and families in additional areas of the state.

Funding: Local, state, Medicaid and CMHS block grant

Initiatives to Prevent Out-of-State Placement

As mentioned previously, the Department of Mental Health is continuing state- and local-level initiatives, most of which involve working with other agencies, to prevent and/or reduce out-of-home or out-of-state placement, such as the State-level Interagency Case Review/MAP Team, as well as local Making a Plan (MAP) Teams. These initiatives are discussed in more detail under Criterion 3.

Other Support Services from Public and Private Resources to Assist Individuals to Function Outside of Inpatient Institutions

In order to manage a crisis after problems are stabilized, other component services available to maintain a child within the community and to divert children and youth from hospitalization are as follows:

Medication Maintenance services are available to children with serious emotional disturbance through the 15 CMHCs. State funding, continues to be provided to support purchase of psychotropic medication for individuals with mental illness who are indigent, including children. Physician evaluations to monitor medication usage, effectiveness and side effects are also available. The DMH continues to provide state funding to support physician services through community mental health programs for children and adults who are not Medicaid eligible.

Respite Services could play a role in preventing hospitalization in some cases, especially if available as part of a comprehensive crisis management system. Objectives to continue implementation of respite programs for children with serious emotional disturbance in FY 2009 are described previously under this criterion.

Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependence Residential Treatment Services for Children and Adolescents all provide needed community-based alternatives to hospitalization and/or other out-of-home or out-of-state treatment for children with serious emotional disturbance. Objectives to maintain, improve, and/or increase these services are described under this criterion.

Mental Health Transformation Activity: Support for Family-Operated Programs (NFG Goal 2.2)

Continued development of family education/support networks and education/training activities and advocacy increase awareness across the system of care of appropriate community-based treatment alternatives to hospitalization or other long-term residential services, as well as of the need for increased support for and availability of these services. Advocacy has not only been a component of the ideal system, but also has been a part of the process of developing and implementing the system of care. Parent education/support and advocacy groups also are important in providing outreach to other parents/families and services, since these groups may be the “first contact” for information or service for some individuals. The Department of Mental Health supported for the development of an education program specifically for parents and families of children with serious emotional disturbance, the Developing Families as Allies curriculum, which was first implemented in FY 1991 in five communities by parent-professional

teams.

Division of Children and Youth continues to provide financial support and technical assistance to Mississippi Families As Allies, Inc., (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. (See previous objective on Respite Services under this criterion.)

An increase in funding for family education and support continues to be available to MS FAA through the second Comprehensive System of Care grant (commUNITY cares). Other MS FAA components of commUNITY cares include youth leadership development; Family Time-Out respite and group respite (including therapeutic recreation). Families in commUNITY cares formed a Family Advisory Council and give input to commUNITY cares governance groups on vision, services and evaluation of the project. Funding for family education and support and respite can also be purchased with flexible funds made available to MAP teams across the state. It should be noted that MS FAA's relationship with the MAP Teams has been a significant factor in developing sites for family education and support.

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. DMH continues to make funding available for family education and support.

In FY 2009, Mississippi Families As Allies for Children's Mental Health, Inc. made available 89 family education support groups serving people from 14 counties and provided 20 family workshops and training opportunities involving 247 participants. NAMI-MS has replaced Visions for Tomorrow and Parent to Parent classes with NAMI-Basics. Five NAMI Basics classes

were held with 40 participants and 24 Parent Support Meetings were held with 152 participants in FY 2009. Additionally in FY 2009, Region 10 CMHC was funded for parenting education classes for the parents of children with SED involved in the juvenile detention center and alternative school. The parent education course meets weekly for 35 classes. By March 2010, Region 10 served 42 families. By March 2010, MS FAA made available 18 family education/support groups serving people in 14 counties and provided 45 family workshops and training opportunities for 79 participants.

Goal: To develop the family education/support component of the Ideal System model for children with serious emotional disturbance

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Family education/support funding

Indicator: Continuation of funding for family education and family support will be made available by DMH.

Measure: Number of family workshops and training opportunities to be provided and/or sponsored by MS FAA (15)

PI Data Table C1.13	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Family Education Groups	8 family education/support groups available through MS FAA (Hinds, Rankin, Madison, Yazoo, DeSoto, Forrest, Harrison and Hancock); 166 families received services from 8 family support specialists at MS FAA.	8 family education/support groups were available through MS FAA (Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, and Hancock counties)			
# Family Workshops/Training Opportunities Provided/Sponsored	MS FAA provided 14 family workshops/training opportunities, with 368 participants; five Parent to Parent classes	MS FAA provided 19 family workshops/training opportunities with 220 participants; five Parent to Parent (NAMI	MS FAA provided 20 family workshops/training opportunities with 247 participants; five Parent to Parent (NAMI Basics)	15	20

	provided by NAMI-MS in 4 regions	Basics) classes provided by NAMI-MS	classes provided by NAMI-MS		
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Source(s) of

Information: Grant awards/monthly cash requests from MS Families As Allies for Children's Mental Health, Inc., MS NAMI, and Region 10 CMHC.

Special

Issues: None

Significance: The need for family education and family support continues to be critical statewide.

Funding: Federal and state funds

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. Started in FY 2002, it now 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 and in 2008 became chapters affiliated with the National Youth MOVE, a new CMHS initiative.

Since 2003, MS Families as Allies for Children's Mental Health, Inc. (MS FAA) has also conducted 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, including participation on the State Level Case Review/MAP Team and monitoring of respite services and family education programs.

Case Management, which focuses on coordinating and accessing appropriate services in the community for children with serious emotional disturbance, plays a vital role in preventing and reducing the risk of hospitalization or other out-of-home placement of children.

Discharge Planning - Prior to discharge from the two state psychiatric hospitals, a referral is made to the CMHC in the region to which the discharged child/adolescent is returning, and an appointment is made at the CMHC for the child or youth by hospital staff, unless permission is denied by the parent/guardian. The state psychiatric facilities maintain information indicating where children/adolescents were referred upon discharge from the hospital, and if they were not referred to a CMHC, the reason why and/or where they were referred. The two adolescent inpatient psychiatric units at the state psychiatric hospitals operate schools, which have approved status by the State Department of Education as special schools. Minimum standards (effective July 1, 2002) for community programs that are designed to facilitate continuity of care include the following requirements: DMH-certified providers must have implemented policies and procedures that ensure that, at a minimum, for youth being discharged from inpatient care, residential treatment centers, and therapeutic group homes, (a) the youth (and family member(s) as appropriate) are given an appointment with a mental health professional within two weeks after referral; (b) the youth (and family member(s) as appropriate) are given an appointment with a physician within four weeks after referral; (c) the youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two weeks after referral for community services; (d) inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and, (e) professional staff have been trained and are knowledgeable in the policies and procedures above.

Interagency agreements are also sought with some public schools to enable adolescents who have progressed in their treatment to attend the local school during the day. Transition assistance is also provided. If the child is not in special education, the hospital school develops an individual program plan. Staff maintain contact with the Special Education Program Developer from the school of origin in order to request and share records. Prior to discharge, hospital staff talk with parents and the local school personnel about appropriate services to transition the child back into the community and local school. Other transitioning services include referrals, as appropriate, to GED programs; to school vocation-technical programs; or, Job Corps for vocational training.

Other Activities Leading to Reduction of Hospitalization

MAP Teams target children/youth with serious emotional disturbance who may be placed inappropriately out-of-home, are at immediate risk of being placed out-of-home or who may be returning to the community from inpatient/residential care. Currently, there are 37 MAP Teams statewide. The State Level Case Review/MAP Team reviews cases concerning children/youth demonstrating emotional/behavioral problems for whom adequate treatment cannot be found at the county or local level and for whom no one state agency has been able to secure all the necessary services through its own resources. This state-level team provides another avenue for preventing or reducing hospitalization for youth with more complex or intensive treatment needs who are most at risk for out-of-home placement. As mentioned, the MS Department of Human Services (DHS), which oversees child custody, instructs appropriate staff in its state and local offices that a MAP team review and recommendation may be made prior to authorization of a

therapeutic placement by DHS and prior to referral to the State-level Interagency Case Review Team. DHS also direct staff that they should refer children in residential treatment to MAP teams in advance of discharge to determine a wraparound support services plan needed by the child and caregiver(s) to maintain them in the community. Cooperative efforts between the Department of Mental Health and the Division of Medicaid described previously in the section on Other Systems Development Initiatives will enhance development of the system of care.

Goal: Decrease utilization of state inpatient child/adolescent psychiatric services

Target: To reduce readmissions of children/adolescents to state inpatient child/adolescent psychiatric services by routinely providing community mental health centers with state hospital readmission data by county

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health services

Indicator: Rate of inpatient readmissions within 30 days and within 180 days

Measure: Ratio of civil readmissions to civil discharges at state hospitals within 30 days and within 180 days.

Sources of

Information: Uniform Reporting System (URS) tables, including URS Table 20 (Rate of Civil Readmission to State Inpatient Psychiatric Facilities within 30 days and 180 days)

Special

Issues: DMH is continuing work on development of the data system to support collection of information for the National Outcome Measures on readmissions to state psychiatric inpatient facilities with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Data was reported through the Uniform Reporting System (URS) tables. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other core indicators over the next three-year period. It should be noted that the current data system does not track individual youth across the community mental health and state hospital systems and although there is some overlap, data are likely to represent two different cohorts. For example, except for receiving a preadmission screening, not all youth served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Youth Court or Chancery Court systems. DMH continued work to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that

passes edits and to have the capacity to track youth served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH and to improve data integrity. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: CMHCs conduct pre-evaluation screening for civil commitment that is considered by courts in determining the need for further examination for and proceeding with civil commitment to the state psychiatric hospitals. Provision of more timely, county-specific data to CMHCs on individuals they screened who were subsequently readmitted will facilitate collaborative efforts to increase continuity of care across hospital and community services settings and increase focus on the provision of community-based services that prevent rehospitalization.

Action Plan: The Department of Mental Health will implement planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization and to provide evidence-based treatment.

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

Decreased Rate of Civil Readmission to State within 30 days and 180 days (Reduced Utilization of Psychiatric Inpatient Beds) (Developmental Tables 20A and 20B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	1.3%	1.3%	.25%	1.2%	.77%
Numerator: Number of civil readmissions to any state hospital within 30 days	5	5	1	4.6	3

Denominator: Total number of civil discharges in the year	384	375	402	390	387
2. Decreased Rate of Civil Readmissions to state hospitals within 180 days	5.99%	5.6%	5.47%	5.9%	5.6%
Numerator: Number of civil readmissions to any state hospital within 180 days	23	21	22	23	22
Denominator: Total number of civil discharges in the year	384	375	402	390	387

National Outcome Measures (NOM): Increased Social Supports/ Connectedness (URS Table 9)

Goal: To increase social supports/social connectedness of youth with serious emotional disturbances and their families (i.e., positive, supportive relationship with family, friends and community)

Target: To continue to monitor case management service plans at the Community Mental Health Centers' annual certification/site visits.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Indicator: Percentage of families of children/adolescents reporting positively regarding social connectedness.

Measure: Percentage of parents/caregivers who respond to the survey who respond positively to items about social support/social connectedness on the *Youth Services Survey for Families (YSS-F)*

Sources of

Information: 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) and case management service plans (reviewed by DMH Division of Children and Youth Services staff).

Special

Issues: Piloting of the *Youth Services Survey for Families (YSS-F)* began in FY 2004. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC), Center to administer the official version of the *YSS-F* to a representative sample of parents of children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 survey was 14%.

Significance: Improving the social support/connectedness of youth with serious emotional disturbances receiving services and their families from the perspective of parents/caregivers is a key indicator in assessing outcomes of services and supports designed to facilitate family-focused systems change. Case management facilitates linkage of services/resources to children/youth and their families, advocacy on their behalf, ensuring that an adequate service plan is developed and implemented, reviewing progress, and coordinating services.

Action Plan: Case managers will continue to provide linkage and referrals to community resources based on their individual needs and monitoring the child's progress as it relates to the child's service plan in the home, school, and community (e.g. direct services, family education/ support, etc.). DMH Division of Children and Youth Services staff will continue to monitor case management service plans for content related to the child/youth's progress in accessing the needed resources or services in the home, school, and community. The community mental health centers are monitored on an annual basis with a follow-up visits made as needed to determine the implementation of their plan of correction on deficiencies noted in the certification /site visit.

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding social connectedness	83%	85%	87%	84%	85%

Numerator: Number of families of children/adolescents reporting positively about social connectedness	243	259	646	260	
Denominator: Total number of family responses regarding social connectedness	294	305	741	308	

National Outcome Measure (NOM): Improved Level of Functioning (URS Table 9)

Goal: To increase satisfaction of parents/caregivers regarding the functioning of their children youth with serious emotional disturbances

Target: Increase or maintain percentage of parents/caregivers of children with serious emotional disturbance who respond positively about their child's functioning

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Indicator: Percentage of families of children/adolescents reporting positively regarding functioning.

Measure: Percentage of parents/caregivers who respond to the survey who respond positively to items about functioning on the *Youth Services Survey for Families (YSS-F)*

Sources of

Information: 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).

Special

Issues: Implementing many of the same initiatives aimed at improving outcomes and described in the previous National Outcome Measure on outcomes is projected to also impact parents'/caregivers' perception of their children's functioning (described in this National Outcome Measure). Trends in parents'/caregivers' satisfaction with outcomes and with their children's functioning appear similar over time (see Performance Indicator tables). Piloting of the Youth Services Survey for Families (YSS-F) began in FY 2004. Since FY 2007, the DMH is has been working with the University of Mississippi Medical Center (UMMC) to administer the official version of the *YSS-F* to a representative sample of parents of

children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 survey was 14%.

Significance: Improving the functioning of children with serious emotional disturbances receiving services from the perspective of parents/caregivers is a key indicator in assessing progress on other goals designed to improve the quality of services and support family-focused systems change.

Action Plan: The DMH Division of Children and Youth Services will continue initiatives described in other sections of the State Plan to disseminate and increase the use of evidence-based practices at the 15 community mental health centers and other nonprofit service programs funded/certified by the DMH, as well as support of the provision of school-based services. The expansion of evidence-based practices and promising practices is aimed at increasing the quality and therefore, the outcomes of services provided to children with serious emotional disturbances and their families. Examples of initiatives to disseminate and expand the use of evidence-based practices include: the participation of several community mental health centers/other nonprofit service providers in learning collaboratives to provide training for implementation of trauma-focused cognitive behavior therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); the provision of training to staff at Gulf Coast Mental Health Center (Region 13 CMHC) in Child-Parent Combined CBT, Trauma Assessment Pathways (TAP), and Psychological First Aid; and, the provision of staff training in CBT and TF-CBT as part of the commUNITY cares System of Care project in the Pine Belt Mental Healthcare Resources service area. The provision of school-based services addresses a primary concern of most parents, that is, the availability of services that support their child's attendance and performance at school.

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding functioning	68%	67%	70%	67%	68%
Numerator: Number of families of children/adolescents	200	203	520	207	

reporting positively about functioning					
Denominator: Total number of family responses regarding functioning	296	305	744	309	

Additional social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (DHS) for families/children who meet eligibility criteria for those specific programs. These services are described in detail under Criterion #3.

Other Support Services are services that typically provide direct reinforcement and/or support for specific behavioral mental health treatment objectives but are not primary direct therapeutic services. In general, these services are coordinated or facilitated by a mental health service professional. Included in this service component would be staff development and training of mental health therapeutic staff and consultation/education of other providers. Also, these services may include (but are not limited to) peer support, mentoring, transportation, and volunteer services. Determining whether or not a service is a support service is based on whether it is necessary to enhance attaining or maintaining direct treatment service objectives.

Private Resources

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, reports 242 licensed and/or CON approved inpatient beds in FY 2009 for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units). The MS Department of Mental Health does not collect data from inpatient facilities in the private sector; that information is maintained by the MS State Department of Health, which licenses those facilities.

Name of Performance Indicator: Evidence Based – Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	33%	33%	33%	33%	33%
Numerator	1	1	1	1	1
Denominator	3	3	3	3	3

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

Target: To continue activities to facilitate dissemination of evidence-based practices in services for children with serious emotional disturbances

Population: Children with serious emotional disturbances

Criterion: Comprehensive Community-Based Mental Health Service System
Children's Services

Indicator: Number of evidence-based practices with DMH funding support available

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

Sources of

Implementation: Division of Children/Youth Services Program grant reports.

Special

Issues: As mentioned in the specific objective on therapeutic foster care (described in the Plan), in accordance with federal URS table reporting instructions, the DMH is currently reporting the number of children receiving evidence-based practices in programs receiving funding support from the public mental health agency. Additional youth receive services through therapeutic foster care programs certified, but not funded by the DMH. Youth also receive Multisystemic Therapy (MST) services through a nonprofit program that is certified, but not funded by the DMH and therefore, those data are not included in the EBP table above. DMH does not currently provide funding specifically for Family Functional Therapy; therefore, data is not available on the provision of FFT.

Significance: The provision of evidence-based practices for children with serious emotional disturbances is key to improving service outcomes for youth and supporting a recovery-oriented approach to treatment and overall system transformation.

Action Plan: The objective to maintain therapeutic foster care services, the EBP that receives DMH funding support and described in the State Plan will be implemented. The Division of Children and Youth Services will also 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.

Criterion 2: Mental Health System Data and Epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1) (Criterion 1, previous section.)

Total Number of Children with Serious Emotional Disturbance

According to final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious emotional disturbance among children and adolescents, (in Federal Register, July 17, 1998), the estimated national prevalence of serious emotional disturbance among children 9-17 years of age is 9-13%. As indicated in the methodology, “if a more stringent definition of impairment is desired than was used (in the methodology) for the estimated range of 9-13%, then the range is from 5-9%. The difference between the two estimates is that the measured level of functional impairment is greater in the second estimate (5-9%) and has been characterized as “extreme functional impairment.” The discussion of these two levels also notes that “Children at both levels of impairment are considered to have a “serious emotional disturbance;” however, the group of children falling into the range of 5-9% constitutes a subset of the 9-13%.”

The federal methodology operationalizes the federal definition of serious emotional disturbance among children and adolescents, published in 1992. The discussion of the methodology notes that “there are no national epidemiological studies of mental disorders for children and/or adolescents that have been conducted in the United States; therefore, in the absence of a national study, the estimated prevalence rates included in the methodology were derived “from eight, smaller and more localized studies.” Currently, “the data are inadequate to estimate prevalence rates for children under the age of nine.” A cut-off score of 50 on the children’s Global Assessment Scale (CGAS) was used for the level indicating more severe impairment (5-9%); a cut-off score of 60 or lower was used for the level indicating the “less conservative definition of serious emotional disturbance”(9-13%).

Prevalence in Mississippi

As part of the early stages of the planning process under P.L. 99-660, the state based its previous estimates of the size of the population of children and youth with significant mental health needs, including those in need of an array of services, on ranges then available and summarized in the professional literature. Current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating the incidence and prevalence of serious emotional disturbance among children and adolescents. Thus, in the FY 2011 State Plan, 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 explained above. Estimates in the FY 2011 State Plan were updated from Uniform Reporting System (URS) Table 1: Estimated number of children and adolescents, age 9-17, with serious emotional disturbances by state, 2009 prepared by the National Association of Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS).

In the methodology, prevalence estimates were adjusted for socio-economic differences across states. Given Mississippi's relatively high poverty rate when compared to other states, the estimated prevalence ranges for the state (adjusted for poverty) were on the higher end of the ranges in the 7/17/98 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:

- (1) 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
- (2) 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

As pointed out in the methodology, there are limitations to these estimated prevalence ranges, including the "modest" size of the studies from which these estimates were derived; variation in the population, instruments, methodology and diagnostic systems across the studies; inadequate data on which to base estimates of prevalence for children under nine; and, inadequate data from which to determine potential differences related to race or ethnicity or whether or not the youth lived in urban or rural areas. As noted in the discussion of the estimation methodology in the Federal Register, "(t)he group of technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that "(I)n the future, incidence and prevalence data will be collected." As explained in the section that follows on the population of children targeted in the FY 2011 Plan, the upper age limit in the definition for children with serious emotional disturbances was extended (beginning in the FY 2003 Plan) to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. The change in Mississippi's definition was made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. Although this constitutes a difference from the federal definition for children with serious emotional disturbance, which defines children as being up to 18 years, it is recognized in the 5/20/93 Federal Register that some states extend this age range as high as to persons less than age 22. In such cases, it was also noted in the Federal Register (5/20/93), that states should provide separate estimates for persons below age 18 and for persons aged 18 to 22. Since Mississippi has extended its age range for children with SED up to age 21 years, and kept its lower age range for adults with serious mental illness at 18 years, 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.

* Civilian population aged 9 to 17 were created by the NRI using Census data from 2009 for the numbers of persons aged 9 to 17 and 2008 federal poverty rates.

** Calculated by Dr. Barbara Logue, Senior Demographer, MS Institutions of Higher Learning, based on 2000 Census data and 2009 Census estimates.

- Goal:** To include in the State Plan a current estimate of the incidence and prevalence in the State of serious emotional disturbance among children, in accordance with federal methodology.
- Objective:** To include in the State Plan an estimate of the prevalence of serious emotional disturbance among children in the state.
- Population:** Children with serious emotional disturbance
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Mental Health System Data Epidemiology
- Indicator:** Utilization of revised estimated prevalence ranges of serious emotional disturbance among children and adolescents (9-17 years of age) in the FY 2011 State Plan (as described above), based on the final estimation methodology for children and adolescents with serious emotional disturbance published in the July 17, 1998 Federal Register.
- Measure:** Inclusion of prevalence estimates derived using federal methodology in the FY 2011 State Plan.
- Source of Information:** Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.
- Special Issues:** There are limitations to the interpretations of this prevalence estimate, explained above.
- Significance:** Estimates of prevalence are frequently requested and used as one benchmark of overall need and to evaluate the degree of availability and use of mental health services.
- Funding:** Federal and state funds
-

Quantitative Targets: Number of Children To Be Served

Goal: To make available a statewide, comprehensive system of services and supports for youth with emotional disturbances/mental illness and their families

Target: To maintain or increase access to community-based mental health services and supports, as well as to state inpatient psychiatric services, if needed, by children with emotional disturbance/mental illness.

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

Indicator: Total number of children with emotional disturbance/mental illness served through the public community mental health system and the state psychiatric hospitals.

Measure: Number of children with emotional disturbance/mental illness served through the public community mental health system and the state psychiatric hospitals

Sources of

Information: Aggregate data in Uniform Reporting System (URS) Tables 2A and 2B, submitted by DMH funded and certified providers of community mental health services to children and by DMH-funded state psychiatric hospitals.

Special

Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. Data was collected and reported through the Uniform Reporting System (URS) tables on persons served in the public mental health system under the age of 18 by gender, race/ethnicity and includes data from both the state-operated inpatient psychiatric unit for children/adolescents and the inpatient unit for adolescents with psychiatric and/or substance abuse problems (which serves only males), as well as youth with any mental illness (not just youth with SED) served in the DMH-funded community mental health service system. It should be noted that at this point in development of the data infrastructure system, combined data (above) from the state inpatient psychiatric units and the public community mental health programs may include duplicated counts.

DMH has continued work on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support from

the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Current plans call for reporting of unduplicated data by the end of FY 2010. As this system continues to be implemented, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed. DMH continued work to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 2. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions and to address other data integrity issues also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: This objective provides an estimate of the service capacity of the public mental health system to provide services to children with emotional disturbance/mental illness.

Action Plan: The Department of Mental Health will continue to make available funding and technical assistance to certified community mental health service providers and the state psychiatric hospitals for the provision of statewide services for youth with emotional disturbance/mental illness.

National Outcome Measure: Increased Access to Services (Persons served in the public mental health system under the age of 18 by gender, race/ethnicity) (Basic Tables 2A and 2B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
Total persons under 18 years served in public mental health system*	30,433*	31,189*	31,821*	30,000	30,000

*Includes youth with any mental illness (not just SED) served in state inpatient units and public community mental health programs funded by DMH. Totals to date do not represent unduplicated counts across programs reporting;

therefore, baseline data are projected as targets as duplication in reporting is addressed in ongoing data infrastructure development activities; downward adjustments are anticipated.

Target or Priority Population to be Served Under the State Plan

Definition of Children with Serious Emotional Disturbance:

As described previously, beginning in the FY 2003 State Plan and in the current Mississippi Division of Medicaid Community Mental Health Manual, the upper age limit in the definition for children with serious emotional disturbances has been extended to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. This is a difference from the federal definition for children, which defines children as being up to 18 years. The change in Mississippi's definition has been made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences.

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.

Community-based Services for Youth with Serious Emotional Disturbances

Public community mental health services for children with serious emotional disturbance will be delivered through the 15 regional community mental health centers and through some other nonprofit community service providers. 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 previous NOM (URS Tables 2A and 2B).

Goal: To make available a statewide, community-based comprehensive system of services and supports for youth with serious emotional disturbances and their families

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

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in community mental health services

Indicator: Total number of children with serious emotional disturbance served through the public community mental health system.

Measure: The count of 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 (28,500)

PI Data Table C2.1	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# SED Served	28,939	29,269	30,199	28,500	28,500

Source(s) of .

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

Special

Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

Significance: This objective provides an estimate of the service capacity of the public community mental health system to provide services to children with serious emotional disturbance, the priority population served by the DMH Division of Children and Youth Services and the population eligible for services funded by the CMHS Block Grant.

Funding: CMHS Block Grant, Medicaid, other federal grant funds as available, state and local funds, other third party funds, and client fees.

The management of children's community mental health services data is also addressed in the information management objective described in detail under Criterion #5.

Mental Health Transformation Activity: Anti-Stigma Campaign (NFC Goal 1.1)

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. The Mississippi Department of Mental Health (DMH) and the Think Again Network will continue 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 through its Think Again campaign.

In October 2009, DMH and the statewide Think Again Network launched a campaign specific to Mississippi entitled, “Think Again.” The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children’s Services and Adult Services State Plans. DMH established the Think Again Network 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.

DMH is conducting a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi’s Think Again efforts have joined forces with DMH’s Youth Suicide Prevention Campaign, “Shatter the Silence.” DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, presentations and the distribution of flyers and brochures on campus. In October 2009, DMH and the Think Again Network launched the Think Again campaign which is an anti-stigma and mental health awareness campaign targeting young adults. Educational materials were developed for the campaign which focuses on the truths about mental illness, how to seek help, and how to fight stigma. Since Oct. 1, 2009, more than 18,000 Think Again brochures and 500 posters have been distributed. DMH worked with the Department of Education to send packets to more than 800 6th – 12th grade public school nurses and counselors with a letter announcing the campaign and offering brochures, posters and presentations free of charge. As a result of the mail out, DMH received requests for more than 8,000 brochures. DMH has conducted more than 70 presentations statewide. DMH continues to combine the anti-stigma campaign efforts with the youth suicide prevention efforts. DMH conducted training in February to prepare 15 individuals to present the Think Again/Shatter the Silence presentations in their community and local schools. In October, several activities were conducted in conjunction with the campaign launch including Weems Community Mental Health Center’s Mind Matters event, Mississippi State Hospital’s Games Your Children Play Part II event, and Central Mississippi Residential Center’s Mental Health Awareness Event. Touglao College sent a text message to all their students announcing the campaign and offering mental health help. More than 20 television and radio interviews have been conducted and more than 70 newspaper articles have been printed reaching more than 900,000 Mississippians.

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

Objective: 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.

Population: Adults and children

Brief Name: Anti-Stigma Campaign – “Think Again”

Indicator: To reach 200,000 individuals during FY 2011

Measure: 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. DMH will also track the number of live interviews and presentations.

MH Transformation PI Data Table	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2007 Plan	1.3 million reached	200,000	200,000	200,000

Source(s) of

Information: Media and educational presentation tracking data maintained by DMH Director of Public Information.

Special

Issues: Activities to plan and kick-off the first year of the three-year anti-stigma campaign began in FY 2007, therefore, the different themes will overlap the fiscal year(s) addressed in the State Plan. The anti-stigma campaign has partnered with DMH's youth suicide prevention campaign for presentations and information distributed to young adults.

Significance: Although youth and young adults, 18-25 years of age, are almost double that of the general population, young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on. The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness.

Funding: Federal, State and/or local funds

As described in detail under Criterion #3 and under Criterion #5, DMH Division of Children/Youth Services staff continues to participate regularly in interagency meetings, conferences and other training events that provide opportunities for increasing awareness across the service system of available children's mental health services. The Division of Children and Youth Services will also continue to disseminate educational materials to the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances. The directory is available through the DMH agency website. As of March 2010, 373 CYS resource directories had been disseminated at conferences or meetings or to individuals, including: A-team Coordinators; MAP Team Coordinators; Piney Woods Health & Resource Fair; CMHC Regions 8, 9, 11, 12 and 13; MS Association of Pediatricians, Mississippi Health Summit, Clinton Public Schools, pre-evaluation screening training participants,

Mississippi State Hospital, foster care and adoptive parents, Mt. Nebo Church Health Fair, participants at the MS Counselors' Association training, and Mississippi Families As Allies for Children's Mental Health, Inc. Presentations were made by the DMH Division of Children and Youth Staff at the following meetings/conferences/agencies: FASD Screening and Referral Trainings (12), Case Management Orientation (2), MAP Team 101 Training, MH/MR Joint Conference, KIDS COUNT Conference, Lafayette County MAP Team, Leadership of Jackson Meeting, MS Child Welfare Institute, Catholic Charities URM Training, MS Coalition on Child Welfare, MS Black Leaders and Caucus Training.

Goal: To increase public awareness/knowledge about serious emotional disturbance among children and services they need.

Objective: 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).

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Information dissemination – general

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.

Measure: Dissemination of directory/other public education material and participation of DMH Children and Youth Services staff in meetings/presentations will be documented.

Source(s) of

Information: Educational material dissemination documented on monthly staffing forms.

Special

Issues: None

Significance: Availability of current information about children's mental health services through printed material and education by DMH staff is a basic component of ongoing outreach services.

Funding: State funds, CMHS block grant, federal discretionary and other grant funds as available.

Mental Health Transformation Activity: Mental Health Services in Schools (NFC Goal 4.2)

Community mental health centers continued to provide information to schools on identification of youth at risk for and with serious emotional disturbances or mental illness and on resources to address the needs of those youth. In FY 2009, informational materials and technical assistance were provided to 822 local schools by community mental health centers. The DMH Division of Children/Youth Services will continue to track the number of schools to which information is made available.

Objective: 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.

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Information/assistance to schools

Indicator: Availability of informational materials and technical assistance to local school districts and other individuals/entities by CMHCs, upon request.

Measure: 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.

Source(s) of Information: Annual State Plan Survey

Special Issues: Tracking of the number of schools to which CMHCs provide educational materials/technical assistance will continue to be a data item on the Annual State Plan Survey in FY 2010. The number of schools requesting/receiving this information can vary across years; therefore, no specific target will be established. If a significant decrease in the number tracked across years is observed, DMH Division of Children/Youth Services will investigate the trend and implement technical assistance to address the issue.

Significance: Availability of informational materials and technical assistance from CMHCs strengthens outreach and service collaboration efforts with local schools.

Funding: Federal, state, and/or local

Criterion 3: Children's Services - in the case of children with serious emotional disturbance, the plan-

- **Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include: social services; educational services, including services provided under the Individuals with Disabilities Education Act; juvenile justice services, substance abuse services; and, health and mental health services.**
- **Establishes defined geographic area for the provision of the services of such system.**

Provisions for an Integrated Service System

State Agency/Office Partners in the System of Care: In Mississippi, coordination of children's services is a cooperative effort across major child and family service agencies. Responsible state agencies are as follows:

State Children's Health Insurance Program, MS Health Benefits: Division of Medicaid, Office of the Governor (lead agency)

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

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

Juvenile 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

Educational Services: Mississippi State Department of Education

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

Rehabilitation Services: Mississippi Department of Rehabilitation Services.

The statewide nonprofit, non-governmental organization that is primarily involved in family education/support and advocacy for children with serious emotional disturbances and their families is Mississippi Families As Allies for Children's Mental Health, Inc.

The geographic areas for the provision of public community mental health services for children and adults is 15 mental health/mental retardation regions, which include the 82 counties in the state.

Community mental health block grant funds for FY 2011 will not be expended to provide any services other than in support of comprehensive community mental health services. (Projected expenditures are described in detail under Criterion 5 in this Plan that follows.)

Mental Health Transformation Activities: Improving Coordination of Care among Multiple Systems and Involving Families Fully in Orienting the Mental Health System to Recovery (NFC Goals 2.2 and 2.3)

Interagency Collaboration Initiatives:

Facilitation of interagency collaboration and coordination among child and family service agencies and families of children with serious emotional disturbance first developed through earlier federal grant projects, including CASSP initiatives and later also supported by a CMHS Local System of Care Development grant, COMPASS in Hinds and Rankin counties, MS, has been a major focus of the Department, the Division of Children and Youth Services and the Planning Council over time. Interagency collaboration and coordination activities exist at the state level and in various local and regional areas. These activities encompass needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives are:

The Interagency Coordinating Council for Children and Youth (ICCCY): As mentioned under Criterion 1, legislation passed in 2001 was extended by Senate Bill 2991, continuing authorization of a state-level Interagency Coordinating Council for Children and Youth (ICCCY) through 2010. The legislation called for the establishment of an Executive Level Interagency Coordination Council for Children and Youth, on which the heads of the state agencies for education, health, human services, mental health, rehabilitation services, Medicaid, and the family organization, MS Families As Allies for Children's Mental Health, Inc., participate. The act further established a mid-level Interagency System of Care Council (ISCC) to perform certain functions and advise the Interagency Coordinating Council and to establish a statewide system of local MAP teams. As of March 2010, the DMH Executive Director continued to serve as chairperson of the ICCCY, and the Director of the DMH Division of Children and Youth Services served as chairperson of the ISCC. The members voted on supporting the reauthorization of the Mississippi System of Care legislation in January 2010, since it will sunset June 30, 2010. In March 2010, HB 1529 was passed during the Regular Session and included revisions to expand the ICCCY and ISCC; to revise the Interagency Agreement, and to revise agencies' policies and procedures to include participation on local MAP Teams.

Goal: Facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels) in development of a system of care for children with serious emotional disturbance.

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Interagency Coordination Council Participation (ICCCY and ISCC)

Indicator: Continued participation by the DMH representatives on the executive level ICCCY and the mid-level Interagency System of Care Council, in accordance with Senate Bill 2991 and continued activities by both Councils in supporting and expanding the systems of care values and principles across the state.

Measure: Minutes of meetings and related documentation of attendance by DMH representatives at meetings scheduled in FY 2011

Source(s) of

Information: 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.

Special

Issues: The Interagency Coordination Council for Children and Youth and the Interagency System of Care Council are comprised of one representative each from the major child and family service agencies and the statewide family organization. Department of Mental Health representatives will participate on the two interagency councils.

Significance: The continued success and expansion of specialized coordinated care programs require ongoing interagency planning and cooperation at the state level.

Funding: State and federal

State-Level Interagency Case Review MAP Team: 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. Agencies represented on Mississippi's team include the Department of Mental Health; the Department of Human Services; the Office of the Governor, Division of Medicaid; the Attorney General's Office; the Mississippi Department of Health; the Mississippi Department of Education and the Department of Rehabilitation Services. MS Families As Allies for Children's Mental Health also has a representative on the team. 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 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. There typically have been numerous interruptions in delivery of services across a variety of attempted services due to frequent moves, failure to show for treatment or for unknown reasons. Cases reviewed by the State-Level

Interagency Case Review/MAP Team must be referred from the local level. The state-level team identifies what has been tried and the services that have been used; it identifies what is available that may meet needs and what services/supports have not been utilized. 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. As local, community-level Making a Plan (MAP) teams continue to be developed in local community mental health regions, linkages with the State-Level Interagency Case Review/MAP Team facilitate assistance to local MAP teams as needed. By March 2010, the State Level Case Review Team reviewed 14 cases of youth diagnosed with SED and at risk of being placed in out-of-state or in-state residential care. The Team followed-up on six of these youth. The Division Director and another staff member coordinated and facilitated team meetings. Since April 2010, DMH is contracting with a Licensed Clinical Social Worker to coordinate and facilitate the meetings and reviews. Meetings are held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

Objective: 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.

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Operation of State-Level Interagency Case Review Team and support

Indicator: Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases and continue to contract with a Licensed Clinical Social Worker for the facilitation and follow-up of cases reviewed. (Documentation of meetings maintained).

Measure: Continued operation of the State-Level team, with meetings on a monthly or as needed basis.

Source(s) of

Information: Monthly Division Activities Report and State Level Case Review Team Staffing forms.

Special

Issues: None

Significance: Continuation of the State-Level Case Review Team is consistent with a provision in the Mental Health Reform Act of 1997 allowing for interagency agreements at the local level, providing another level of interagency review and problem-solving as a resource to local teams that are unable to/lack resources to address the needs of some youth with particularly severe or complex issues.

Funding: Local, state, and/or federal funds for salaries of staff from represented agencies/programs; funds will also be available when needed for family members' travel expenses.

The State Level Case Review/MAP Team is facilitated by the Division Director of Children and Youth Services and an assigned Division staff. In FY 2009, the DMH continued to make available funding for the State Level Interagency Case Review/MAP Team to distribute for services for children/youth reviewed by that team and for which funding and/or other resources do not appear accessible at the local level, including youth who reside in counties without MAP Teams. Those youth from communities in which there is no local MAP team with funding will have priority. The state-level team will facilitate a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home. As of March 2010, DMH continued to provide the State Level Interagency Case Review/MAP Team with funding to purchase critical services and /or supports identified as needed for 14 targeted children /youth with SED reviewed by the team.

Objective: 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.

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: State-Level interagency team funded

Indicator: Availability of funding from DMH Division of Children and Youth Services to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team.

Measure: Availability of funding and the number of children served using this funding for wraparound services

Source(s) of

Information: Documentation of grant award on file at DMH; monthly cash requests.

Special

Issues: None

Significance: This is the first flexible funding (other than existing resources) available to the state-level team for providing services.

Funding: Federal (CMHS Block Grant)

Making A Plan (MAP) Teams

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, which vary from team to team, also might participate in the planning or service implementation process. Examples of providers of community supports include youth leaders, ministers or other representatives of children/youth family service organizations in a given community. Thus, implementation of the plan might involve accessing a variety of informal or formal resources in the community and maximizing use of a variety of funding sources.

Also, as mentioned, if a MAP team is available in the county, the Department of Human Services continues to encourage appropriate state and local workers in the agency to present cases to the MAP team of children with serious emotional disturbance in DHS custody and/or receiving DHS services who are being considered for placement in or who are in need of a discharge plan from psychiatric inpatient or long-term residential care and/or prior to referral to the State Level Interagency Case Review Team.

DMH Division of Children and Youth Services coordinates regular meetings with MAP team coordinators to which representatives from the state hospitals child/adolescent units and the Department of Human Services representatives are invited. By March 2010, the Division of Children and Youth Services Director had coordinated three statewide meetings with the local MAP Team Coordinators. The following topics were discussed: the Fetal Alcohol Spectrum Disorders screenings and trainings, the Mississippi System of Care Assessment and Study Report, ICCCY/ISCC activities, MYPAC, case reviews, MAP Team expansion, transitional age youth, and juvenile justice. Technical assistance was provided to MAP Teams in CMHC regions 2, 5, 6, 7, 9, 11, 13 and 15. Technical assistance regarding the expansion of MAP Teams was provided to Regions 2, 6, and 11.

Objective: 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 providing services and supports for children/youth with SED and their families.

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Technical assistance provided for MAP teams

Indicator: Provision of MAP team local coordinators meetings for networking among MAP teams.

Measure: Number of meetings of MAP Coordinators led by a designated Children/Youth

Services staff member (at least four) and number of local MAP team meetings attended by DMH representatives.

Source(s) of

Information: Monthly Division Activities Report and minutes of local MAP team meeting.

Special

Issues: None

Significance: Revisions to the DMH Minimum Standards require each CMHC region to participate in or establish one MAP team. Regular meetings with DMH staff and other MAP team coordinators across the state aid in local interagency development though group discussions of barriers, strengths, procedures and other related issues on local infrastructure.

Funding: Federal, state and/or local

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. In FY 2009, one DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. Region 8 received additional funding for children with fetal alcohol spectrum disorders. A total of 37 MAP teams continued to operate statewide, with access to flexible funds through the 15 CMHCs and Catholic Charities. By March 2010, one DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. Forty-three counties either had a MAP Team or access to one, and all 37 MAP Teams continued to operate statewide and had accessibility to flexible funds.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: MAP team funding

Indicator: Availability of funding through DMH for MAP teams.

Measure: Number of MAP teams that receive or have access to flexible funding through DMH. (Total of 38 teams)

PI Data Table C3.1	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# MAP Teams with Flexible	16	16			

Funding					
# MAP Teams with access to flexible funding			37	35	38

Source(s) of

Information: Documentation of grant awards; Monthly MAP team reports; monthly cash requests.

Special

Issues: Additional information from the MAP teams tracked includes services purchased and the number of youth staffed/served.

Significance: The ultimate goal of this initiative is to expand the availability of these teams statewide.

Funding: State and federal

The DMH Division of Children and Youth Services continues to participate in multiple efforts to enhance interagency collaboration across the system of care at the state and local levels. In FY 2009, the DMH Division of Children and Youth Services staff participated on the following interagency committees and workgroups: the Interagency Coordinating Council for Children and Youth (ICCCY), the State Level Interagency Case Review Team, the DHS Citizen Review Board, MS Alliance for Health (MASH) Conference Planning Committee, Interagency System of Care Council, *Lookin' to the Future* Conference Planning Committee, Advisory Council for FASD, MS Association of Drug Court Professionals (MADCP) Drug Court Conference Committee, American Association of Pediatrics Mental Health Task Force, Underage Drinking Task Force (MAAUD), Prevent Child Abuse Advisory Council, Multicultural Task Force, Youth Suicide Prevention Advisory Council, "Cradle to Prison Pipeline" Summit Planning Committee (Children's Defense Fund), commUNITY cares (System of Care project) Core Committee, Sustainability Committee and the Cultural & Linguistic Committee, and the Case Management Task Force. DMH Division of Children and Youth Services staff also attended meetings of the Children's Services Task Force of the Mississippi State Mental Health Planning and Advisory Council.

By March 2010, the DMH Division of Children and Youth Services staff was participating on the following interagency committees and workgroups: the Interagency Coordinating Council for Children and Youth (ICCCY), the State Level Interagency Case Review Team, the DHS Citizen Review Board, MS Alliance for Health (MASH) Conference Planning Committee, Interagency System of Care Council, *Lookin' to the Future* Conference Planning Committee, Advisory Council for FASD, MS Association of Drug Court Professionals (MADCP) Drug Court Conference Committee, American Association of Pediatrics Mental Health Task Force, Underage Drinking Task Force (MAAUD), Prevent Child Abuse Advisory Council, Multicultural Task

Force, Youth Suicide Prevention Advisory Council, the “Cradle to Prison Pipeline” Summit Planning Committee (Children’s Defense Fund), and the Case Management Task Force. DMH Division of Children and Youth staff also continued to support System of Care projects and participated on the commUNITY cares Core Committee, Sustainability Committee, and, the Cultural & Linguistic Committee; and, on the MS Transitional Outreach Project Executive Council, Core Committee, and Cultural & Linguistic Committee. DMH Division of Children and Youth Services staff continued to serve on the Juvenile Justice Mental Health Task Force, the Transitional Age Task Force, and the Jackson Public Schools Safe Schools/Healthy Students Initiative. Meetings of the Mississippi State Mental Health Planning and Advisory Council were also attended by staff from the Division of Children and Youth.

Department of Mental Health staff will continue to participate in a variety of state-level interagency collaboration activities and will provide support for interagency collaboration at the local level in the 15 CMHC regions. These efforts will 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. Local infrastructure building strategies will continue to be addressed with audiences of CMHC children’s staff, as well as families and representatives of county offices of DHS Family and Children’s Services (Child Welfare), Youth Services (Juvenile Justice); local school districts; health; and other key community providers or leaders when identified.

Objective: 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.

Population: Children with serious emotional disturbance

Criterion: Children’s Services

Brief Name: Participation on interagency committees

Indicator: Participation of DMH Children/Youth Services staff on state-level interagency councils or committees.

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

Source(s) of Information: Monthly Division Activities Report

Special Issues: None

Significance: 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.

Funding: State funds, local funds, other federal discretionary, and private foundation grant

funds as available.

Additional interagency initiatives involving partners in the system of care are described in this section. DMH Division of Children and Youth will continue to make available information to relevant children's service providers across the system of care on training opportunities and technical assistance pertaining to their area(s) of service, such as through continued support of an annual statewide conference addressing the system of care. (See Criterion #5.) Some of the training/technical assistance may be provided by DMH Division of Children and Youth Services staff, with some provided by other social or health services providers, university faculty, and/or family members/educators.

Health and Mental Health Initiatives

State Children's Health Insurance Program: Mississippi Health Benefits Program

Implementation of the MS Health Benefits Program for the provision of medical and dental benefits is described under Criterion 1.

Substance Abuse Initiatives

In recent years, as described previously under Criterion #1 (Special Populations), the Bureau of Community Services and the Bureau of Alcohol and Drug Abuse have increased targeted efforts to better identify youth with emotional disturbances who might also have substance abuse treatment needs. Refer to Criterion 1 for specific objectives related to coordination across systems to provide mental health and substance abuse services to youth with a dual diagnosis. Efforts will continue in identification of more children and youth in community-based services who are initially identified only as having a serious emotional disturbance who also may have a substance abuse diagnosis. Also, as mentioned previously, the Directors of the Division of Children and Youth Services and the Bureau of Alcohol and Drug Abuse Services continue to collaborate on fetal alcohol spectrum disorder issues.

Social Services Initiatives

Recognizing the wide array of services needed by children and youth with serious emotional disorders and their families, the Department of Human Services, Division of Family and Children's Services staff seek to put into place a coordinated, cohesive system of care with child-centered and family focused activities focusing on local and state infrastructure building, technical assistance to providers and others, and public awareness and education. A wraparound approach to delivery of services is being developed in an effort to make those services needed accessible and appropriate for each child and family. CMHCs, the State-Level Case Review Team and several local Making a Plan (MAP) Teams, crisis lines, and other child-serving agencies and task forces assist the child/youth and family to access the system of care.

Specific social services are available to children with serious emotional disturbance administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The MDHS Division of Family and Children's

Services provides child protective services, child abuse/neglect prevention, family preservation/support, 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 MDHS Division of Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program (TWP), Supplemental Nutrition Assistance Program (SNP), SNAP Nutrition Education and the “Just Wait” Abstinence Education program. The MDHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, A-Teams coordination, and oversees the state training schools. The MDHS Division of Child Support provides child support location and enforcement services, educational parenting programs, mediation, counseling programs, monitored and supervised visitations, and pro-se workshops and non-custodial visitation programs. The MDHS Office for Children and Youth provides certificates for child care services for TANF and Transitional Child Care (TCC) clients, children in protective services or foster care, as well as low income eligible working parent(s) or parent(s) in an approved full-time education or training program. The MDHS Division of Aging and Adult Services provides resources to the elderly and disabled population through the system of Area Agencies on Aging. The ADRC/Mississippi Get Help provides a website for services and resources available throughout the state. One phone call provides access to trained Information and Assistance Specialists, who help with referrals to agencies and/or services, eligibility information, application assistance to apply for services, long-term care options counseling and follow-up.. The MDHS Division of Community Services provides services such as homeless resource referrals low income utility assistance, weatherization of eligible clients’ homes and the Fatherhood Initiative Program. Through Community Services Block Grant (CSBG), the Division of Community Services offers health and nutrition programs, transportation assistance, education assistance, income management, housing and employment assistance.

Educational Services Under the Individuals with Disabilities Education Act of (2004)

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).

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.

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 to enable him or her 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 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.

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.

MDE has implemented a system of focused monitoring that uses continuous review and utilization of data to ensure improvement. Annual data profiles are provided to districts and to the public, and Local Education Agencies are ranked on the priority indicators to identify districts for focused monitoring and those in need of improvement. One of the priority indicators is identification of children with emotional disabilities. All districts must conduct an annual self-review by analyzing data, reviewing records and developing improvement plans that address issues identified in the self-review. Districts in need of improvement must submit improvement

plans. Those receiving focused monitoring visits must submit improvement plans that address each identified area of noncompliance. Follow up visits are conducted to ensure implementation of corrective actions. Focused monitoring includes predictable sanctions and rewards to ensure that all districts are improving. Based on data from MDE, the number of children with emotional disabilities identified in the schools has increased for the last five school years.

As mentioned under Criterion 1, the Division of Children and Youth Services targets many of its outreach efforts to school settings through provision of educational materials and presentations. 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. Objectives related to expanding school-based community mental health services are located under Criterion 1 and Criterion 4. Representatives of the MDE are participants in state-level interagency groups described previously in this section, and local school district representatives are participants on local Making a Plan teams. Community mental health centers also provide training on children's mental health services to local teachers.

National Outcome Measure (NOM): Percent of Parents Reporting Improvement in Child's School Attendance (URS Table 19B)

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

Target: To continue to require CMHCs as per DMH Minimum Standards, to offer mental health services to each local school district in their region.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Indicator: Increase in the percentage of families of children/adolescents reporting improvement in child's school attendance (both new and continuing clients)

Measure: Percentage of parents/caregivers who respond to the survey and who report improvement in their child's school attendance on the *Youth Services Survey for Families (YSS-F)*

Sources of

Information: Uniform Reporting System (URS) data from Table 19B, which are 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) and interagency agreements between schools and CMHCs providing school-based services.

Special

Issues: In addition to the data being based on self-report, the relatively low number of total responses to this survey item compared to the number of responses to other items on the survey, and the relatively high number of "not applicable/no

responses (273 in 2009) excluded from the total responses to this item in calculating percentage of improvement should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of “branching” questions added to the end of the original YSS-S survey instrument to gather information on this NOM), which may be confusing to some respondents.

Significance: School attendance and performance are vital to the development and progress of all youth and are of special concern to parents/caregivers of youth with serious emotional disturbance. School-based therapists are able to track school attendance for those children/youth on their caseload and have the opportunity to facilitate attendance through therapy and consultation services provided to the child, family and the school.

Action Plan: 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. The provision of school-based mental health services is projected to facilitate access to community mental health services, especially in rural areas and to positively impact school attendance by those children and families served by CMHCs.

National Outcome Measure (NOM): Percent of Parents Reporting Improvement in Child’s School Attendance (URS Table 19B).

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of Families of children/adolescents reporting improvement in child’s school attendance	54.2%	44.3%	41%	48%	44%
Numerator: Number of families of children/adolescents reporting improvement in child’s school attendance (both new and continuing clients)	89	78	158	95	

Denominator: Total number (including Not Available) (new and continuing clients combined)	164	176	385	196	
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Mental Health Transformation Activities: Juvenile Justice Initiatives

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.

Juvenile Justice Interagency Training

Senate Bill 2894, passed in 2005, called for the establishment of A Teams, modeled after existing Making A Plan (MAP) teams and designed to focus on the identification and planning of resources for youth in the juvenile justice system who might have serious emotional disturbances (SED). The members of the A Teams include a DHS Youth Court counselor, a representative of children's mental health services from a community mental health center, a family member in the community who either has or has had a child in the juvenile justice system, a school attendance officer or counselor and a social worker from the DHS Division of Family and Children's Services. DMH worked with the Mississippi Department of Human Services (DHS) to develop and provide training for A-Team members in all seven DHS service areas in the state.

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

Target: To continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by DMH.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

Indicator: Increase in 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

Measure: Percentage of children/adolescents served by the public community mental health

system reported by parents/caregivers as arrested in Year 1 (T1) who were not rearrested in Year 2 (T1)

Sources of

Information: Uniform Reporting System (URS) data from Table 19A, which are 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), certification reports and Division of Children & Youth Services Monthly activity log (for technical assistance).

Special

Issues: In addition to the data being based on self-report, the low number of total responses to this survey item (43 in 2009) compared to the number of responses to other items on the survey should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of “branching” questions added to the end of the original *YSS-S* survey instrument to gather information on this NOM), which may be confusing to some respondents, as well as to some parents’/caregivers’ reluctance to respond to questions about their child’s involvement in the justice system.

Significance: Adolescent Offender Programs represent a state-level and community based partnership among the Department of Human Services, Department of Mental Health, the Youth Court Judges, community mental health centers, and other local community non-profit agencies. Adolescent Offender Programs provide youth with a safe, controlled environment in which counselors teach the adolescents appropriate social skills, interpersonal relationship skills, self control, and insight. AOP’s provide a mechanism within communities to coordinate services, share resources, and reduce the number of youth offenders being placed in state custody.

Action Plan: To continue collaboration with the Mississippi Department of Human Services in the maintenance and expansion of AOPs by providing technical assistance and certification for the required mental health component of AOPs.

National Outcome Measure (NOM): Decreased Juvenile Justice Involvement (URS Table 19A).

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of children/adolescents Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	57	33	50	46	44%

Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	8	4	14	6	
Denominator: Total number of children/adolescents arrested in T1 (new and continuing clients combined)	14	12	28	13	

Mental Health Transformation Activities: Initiatives to Assure Transition to Adult Mental Health Services

In recent years, 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.

Transitional Services Task Force: A task force formed to better identify and plan to assess needs of youth, age 18 to 25 years, continued its interagency initiatives in FY 2009 and will continue in FY 2010. The task force began meeting in July 2003, further defining the direction for identifying and serving youth with serious emotional disturbances or mental illness in this age group. The group has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14. This has been identified as an age at which children/youth begin to fall out of the system. Through learning about the Transitional-Outreach program, which is funded by the Department of Mental Health, 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. In FY 2005, coordination of the Transitional Services Task Force was assigned to the DMH Division of Children and Youth Services staff member who works specifically with those programs that serve transition-age youth. 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 group 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. 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 will provide funds for the implementation of six additional Transitional Outreach Programs (TOP) across the state.

Additionally, as explained under Criterion #2, changes made in prior years to the definition of children with serious emotional disturbance in this Plan and in the Medicaid Mental Health (CMH) Provider Policy Manual included extending the upper age limit to up to 21 years, while the lower age range for adults with serious mental illness remains at 18 years. This change allows more flexibility in individualization of services for youth 18 to 21 years, including access to services in either the child system or the adult system, depending on the strengths, needs, and preferences of the individual young person.

Mental Health Transformation Activity: Improving access to affordable housing and employment/supports)

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 18 to 21 years. Part of Mississippi's FY 2000 CMHS Block Grant increase was used to provide an additional clinical coordinator to partner with an existing coordinator to facilitate and enhance services across all therapeutic group homes operated by one provider. In FY 2009, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and two homes operated by Hope Village. Four of the homes received DMH funding support. By March 2010, DMH certified and continued funding for 4 transitional therapeutic group homes (Rowland, Harden House, and two programs operated by Hope Village). DMH also continued to certify two more transitional therapeutic group homes (PALS and PALS II).

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Transitional residential and supported living program funding

Indicator: Continued funding of two transitional living services group homes and two supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.

Measure: The number of transitional therapeutic group homes and/or supported living programs that will receive funding through DMH for mental health service (four)

PI Data Table C3.5	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Transitional Living Homes/ Supported Living Programs Funded	2	Two group home programs served 40 youth, and two supported living programs served 95 youth	4 transitional living programs; two additional programs were certified, but not funded by DMH	Four transitional living programs	Four transitional living programs

Source(s) of

Information: Grant awards to continue funding to the targeted transitional living services/supported living programs.

Special

Issues: None

Significance: This funding supports the provision of mental health services needed by these youth that facilitates their transition to a more independent setting.

Funding: Federal, state, local funds

Criterion 4: Targeted Services to Rural and Homeless Populations-

- **Describes States' outreach to and services for individuals who are homeless**
- **Describes how community-based services will be provided to individuals residing in rural areas.**

Outreach to and Services for Youth/Families Who Are Homeless

During the first part of FY 2009, specialized services for homeless/runaway youth were provided through Our House, operated in Jackson by Catholic Charities, Inc. Our House was designed to provide a safe place or environment and focuses on eventually returning youth to their homes. "Project Safe Place," an outreach service of Our House, provides a network of 34 "Safe Place" sites where youth can go for immediate help, and outreach on 50 public transportation buses throughout the Jackson community. In FY 2009, the DMH continued to provide at the 50% level of funding for the SAFE Place coordinator salary. Our House Emergency Shelter reported serving 43 youth in FY 2009. The target number of children (90) was not reached as a result of the closure of the shelter March 31, 2009. Adult volunteers who are trained in crisis intervention offered assistance and transportation to the shelter for youth who could not return home. Our House Residential Program transitioned from a residential-based program to the community host

homes model, which is under the therapeutic foster care umbrella of Catholic Charities, Inc. Youth being served the last weeks of the program returned to their home. By March 2010, Division of Children and Youth Staff made two technical assistance visits and conducted a certification review of Catholic Charities Inc., Host Homes Program. Certification of the Host Homes Program, funded by a grant from the Department of Health and Human Services, Administration of Children and Families, began on March 1, 2010. The Catholic Charities, Inc. Host Home Program (HHP provides shelter, counseling and prevention services for runaway and homeless youth. The shelter service is provided using the Host Home model, with host homes recruited throughout the tri-county metro area. The HHP provides 24-hour service and accessibility to youth who are eligible for services, while maintaining strict confidentiality. Youth and families receive individual and family counseling, case management and service linkage, in addition to access to transportation services. Professional staff work collaboratively with the school system to enhance academic endeavors. The HHP develops a plan for aftercare services upon admission to the program. If family reunification is not feasible then alternative permanent placements for youth are sought. The overall goal of the HHP is reunification of youth with their families or securing appropriate permanent placements to move these adolescents toward successful independence. The award year for the grant ends September 30, 2010. Catholic Charities, Inc. did not pursue funding for the upcoming award year for the Host Homes Program due to the insufficient number of runaway and homeless youth needed to support the goals and objectives of the grant. As of October 1, Catholic Charities, Inc. Host Homes Program will be merging with the Therapeutic Foster Care Program to provide short-term (45 days) foster care services. Safe Place sites for youth in crisis will be maintained by the therapeutic foster care program. As the need arises with the runaway and homeless population, services will be provided via service linkage or placement.

The Domestic Violence Center, also operated by Catholic Charities, Inc. in Jackson, by the nature of its program, provides additional outreach services to women and children who are already homeless or potentially homeless because of domestic violence. Additionally, this program is linked to a network of crisis and treatment services, also operated by Catholic Charities. Similarly, the Gulf Coast Women's Center, which operates a crisis intervention program for children and families (with funding from the DMH) as a component of a domestic violence program, provides outreach to homeless or potentially homeless women and children. In addition, this program also provides care coordination services such as making referrals, securing housing, medical/dental care, and educational services to children and youth with serious emotional disturbances or youth at risk for emotional illness entering the center. In FY 2003, the Gulf Coast Women's Center began receiving PATH grant funds (federal grant for homeless individuals with mental illness) to address the needs of the women served by the center. (See Criterion #4, Adult Services Plan). In FY 2009, the Gulf Coast Women's Center reported having served 71 youth, 60 of whom were children with SED or at risk for emotional illness. By March 2010, Gulf Coast Women's Center had served 70 children with SED or at risk for emotional illness. These children were served in an emergency homeless shelter setting that is specific to domestic violence.

Beginning in FY 2000, funds were made available to Region 13 CMHC (Gulf Coast Mental Health Center) to provide 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. In FY 2009, Region 13 had provided services to 294 children from the local shelter for abused/neglected children, all of whom were enrolled in the services at Region 13 and had a serious emotional disturbance. By March 2010, funding continued to be provided to Region 13 to support services to a local shelter for abused/neglected children that provided services to 70 children.

The Division of Children and Youth Services has continued collaboration with these specialized programs and plans to continue helping support the outreach/crisis intervention capacity of these programs and will continue to be available to three currently funded programs to enhance their outreach and service initiatives to youth who are homeless/potentially homeless in FY 2010.

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

Population: Children with serious emotional disturbance or at risk for emotional illness

Criterion: Targeted Services to Homeless and Rural Populations

Brief Name: Crisis intervention services to youth and families in a nonviolence shelter

Indicator: Continued 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.

Measure: The number of children served through this specialized program (100)

PI Data Table C4.2	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Children in Domestic Violence Situation Served	8	74	71	100	100

*Gulf Coast Women’s Center was significantly impacted by Hurricane Katrina and its operations disrupted, but initial targets for FY 2005 were met since the storm occurred toward the end of the period. Targets for subsequent years were more conservative, considering the recovery period.

Source(s) of

Information: Grant proposal for existing program.

Special

Issues: 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.

Significance: This Gulf Coast Women's Center for Nonviolence provides shelter for children and their mothers who are experiencing violence at home. This center operated a 24-hour crisis line, provides housing and supportive residential services, court advocacy, community education, intensive counseling for children with serious emotional disturbance and a therapeutic preschool program.

Funding: Federal

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

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Crisis intervention services for youth in a shelter program

Indicator: Continued funding to support a CMHC in providing crisis intervention services, a therapist and other needed supports to a local shelter for abused/neglected children.

Measure: The number of children served through this specialized program (200)

PI Data Table C4.3	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Abused/ Neglected Children Served	298*	353	294	100	200

Source(s) of Information: Grant proposal for the targeted CMHC

Special Issues: None

Significance: Through this program, a CMHC therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the shelter. Staff at the shelter are also provided training by the CMHC in crisis intervention techniques, behavior modification, communication issues, children's reaction to abuse and neglect, and recognizing indicators of sexual abuse. The shelter serves children who have allegedly experienced abuse and/or neglect.

Funding: Federal

Therapeutic Group Homes and Therapeutic Foster Care Services

Although all children served through therapeutic foster care or in therapeutic group homes are not “homeless,” a large percentage (75% - 85%) are in the custody of the Department of Human Services and are “foster children.” The objectives for these services are under Criterion 1, and relate to meeting the needs of these foster children.

Coordination with Other Agencies

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). These programs most likely will include emergency shelters approved by the Department of Human Services and/or other appropriate state agencies.

Goal: Facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels) in development of a system of care for children with serious emotional disturbance.

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

Population: Children with serious emotional disturbance

Criterion: Targeted Services to homeless/runaway youth

Brief Name: Educational opportunities for staff

Indicator: Provision of information on applicable training/education opportunities made available through the DMH Division of Children and Youth Services to programs serving children/youth with serious emotional disturbance.

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

Source(s) of Information: Children and Youth Monthly Staffing Forms

Special Issues: None

Significance: Homeless/runaway youth, including youth with serious emotional disturbance, are more likely to be in emergency shelters approved by the Department of Human Services and/or other appropriate state agencies; therefore, these shelters will be

targeted for inclusion in applicable children's mental health training activities.

Funding: State and local funds, CMHS, federal discretionary, and other grant funds

Definition of areas of the state considered "rural"

In its continued efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas, the Department of Mental Health will use the new definition of "rural," based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:

"Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)" are classified as "rural." More specifically, the Census Bureau "delineates UA and UC boundaries to encompass densely settled territory, which consists of:

- Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
- Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are "split" between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural."

Outreach Efforts and Services to Address Barriers to Access by Individuals in Rural Areas

Regionalization of Services: Availability and accessibility of services for children with serious emotional disturbance and their families in rural areas are addressed through some of the same structural and programmatic characteristics of the public community mental health system, as described under Criterion 4 in the Adult Plan. These include regionalization of community mental health services, county mental health offices and school-based services. Expansion of children's mental health services within the existing regional system, so that components of the system of care are available statewide, is the ultimate goal of planning and service development efforts reflected in the State Plan.

Mental Health Transformation Activity: Mental Health Services in Schools (NFC Goals 3.2 and 4.2)

Emphasis on School-Based Services: 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. For the past few years, individual, group therapy, family therapy, and school-based day treatment programs have become available through an increasing number of school districts through school-based CMHC therapists. Case managers facilitate significant outreach efforts in rural communities across the state by building communication between school and home and across other community services. (See objectives on school-based outpatient and

day treatment services and on case management services, under Criterion 1.)

Since much of Mississippi remains rural, 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. Linkages with schools, which have continued to expand over the last several years, have been received positively by both families and school staff across the state. School district personnel have demonstrated significant willingness to promote accessibility to mental health services at school sites. Technical assistance regarding strategies for expanding and gaining access to services will continue to be made available, upon request, by DMH Division of Children and Youth Services staff as each CMHC region is visited and through specific training sessions/workshops, and activities facilitated by the Division, i.e., case management training, crisis management training and financing strategies.

In FY 2009, DMH Division of Children and Youth Services staff had provided certification visits and technical assistance regarding the expansion of school-based services to all 15 CMHC regions. By March 2010, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to CMHC regions 1, 2, 3, 5, 6, 7, 9, 10, 14, and 15.

Goal: To further support the availability of, and access to children's mental health services across all counties in all 15 community mental health regions.

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

Population: Children with serious emotional disturbance

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Technical assistance on service expansion

Indicator: Availability of technical assistance regarding the availability of and access to school-based services across CMHC regions.

Measure: Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools.

PI Data Table C4.4	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Providers Receiving T.A. /certification visits	15	10	15	15	15

Source(s) of

Information: Monthly Division Activities Report

Special

Issues: Technical assistance is typically provided upon request, which will make the number of CMHCs that receive such assistance vary across years.

Significance: The availability of mental health services in schools is a major strategy in reaching children with serious emotional disturbance and their families who live in rural areas, particularly those with limited or no transportation. Technical assistance/training opportunities offered to CMHCs on service expansion throughout the year are recorded monthly by DMH staff.

Funding: Federal, state, and local funds

Transportation Assistance is provided by some community mental health centers that have vehicles for transportation or through other child service agencies in some areas. For example, in FY 2008, 13 CMHCs and eight other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; 11 CMHCs and one other nonprofit program reported making transportation available through affiliation agreement with other agencies; and, five CMHCs and four other nonprofit programs reported utilizing local public transportation (buses, cabs, etc.).

The Telepsychiatry Project (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), with plans for expansion to some satellite sites in FY 2010. The project also is designed to provide training to front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing).

Criterion #5: Management Systems -

- **Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan.**
- **Provides for training of providers of emergency health services regarding mental health**
- **Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved (FY 2011)**

Children's Community Mental Health Services

Financial Resources	Available in FY 2009 2010	Projected FY 2011
Federal Grants (CMHS, SSBG)	4,172,380	4,172,380
State Funds (grants, Medicaid match)	9,501,267	9,501,267
Healthcare funds (grants, Medicaid match)	1,032,783	1,032,783
Trf. from CMHCs for Medicaid match	3,816,900	3,816,900
Local Taxes*	4,128,038	4,128,038
Local Fees	2,250,000	2,250,000
Federal Medicaid Reimbursements*	61,033,500	61,033,500
Total	85,934,868	85,934,868

*Based on estimated use of funds for children's services of 45% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

Efforts to Increase Funding

Mississippi's budget process is such that funds the Department of Mental Health requested in the 2010 legislative session, which began in January of 2010, would be made available for the fiscal year that begins July 1, 2010, and ends June 30, 2011. In its initial budget request for FYE 6/30/2011, the Department of Mental Health requested an increase of \$56,030,731 (an increase of about 25½%). This requested increase was for all services provided through the Department (mental health services for adults and children, services to persons with substance abuse diagnoses, services to persons with intellectual and developmental disabilities, and services to persons with Alzheimer's disease and other dementia; inpatient and outpatient services in all areas). Included in that requested increase, which totaled \$45 million, were (1) funding to replace loss of enhanced Federal share of Medicaid under the American Recovery and Reinvestment Act (about \$13 million); (2) additional funding to fully fund Medicaid match for the CMHC program (about \$30 million) and (3) funding to replace a reduction in grant funding (about \$2 million). None of the requested increase was awarded. Additionally, the original general fund appropriation for FYE 6/30/10 (approximately \$220,500,000) was cut to about \$200,000,000 during the fiscal year due to declining tax revenues. This cut was taken entirely from residential

and institutional based services. The financial situation for the next fiscal year (FYE 6/30/12) does not really appear any better. DMH will be addressing funding for that fiscal year during the legislative session that will begin in early January 2011.

Goal: To increase funds available for community services for children with serious emotional disturbance.

Objective: The DMH will seek additional state funds for community mental health services for children with serious emotional disturbance.

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems

Brief Name: Funding Increase Request

Indicator: The Department of Mental Health will seek additional funds in its FY 2012 budget request for community support services for children with serious emotional disturbances.

Measure: Inclusion of request for increased state funds to support community mental health services for children in the FY 2012 DMH Budget Request.

Source(s) of Information: DMH Budget Request, FY 2012

Special

Issues: Based on the estimated use of funds of 45% for children's services of the total to be requested for adults' and children's community mental health services, this percentage is currently reflected in the projection for additional state matching funds for adult mental health services provided by CMHCs and funded through Medicaid (in preceding projected budget request).

Significance: Increased availability of state funding for community mental health services will positively impact the rate of expansion of the services for which any increase is received.

Funding: State

**Staffing
Human Resources, CMHCs**

POSITION	Total Staff
1. Psychiatrists	27
2. Other Physicians	8
3. Psychologists, Ph.D.	11
4. Staff with Master's Degree or Above in Field of Psychology	75
5. Other Psychologists	14
6. Social Worker (MSW, Other Master Degree or Above.	209
7. Other Social Workers	58
8. Registered Nurses (AA or Above)	41
9. Licensed Practical or Vocation Nurses	14
10. Other Mental Health Professionals (Bachelor Degree or Above)	484
11. Other Mental Health Workers (Less that Bachelor's Degree)	423
12. Physical Health Professionals	8
13. All Other Staff (clerical, maintenance, etc.)	319
14. Totals	1691

Mental Health Transformation Activities: Workforce Development

Training of Mental Health Service Providers and Families across the System of Care

Local Infrastructure Development: In FY 2009, the DMH, Division of Children and Youth Services continued to seek opportunities to provide or arrange for technical assistance and training for CMHC and other providers receiving funds through the DMH. Division of Children and Youth Services staff provided and/or facilitated the following training on for providers of mental health services for children/youth: "FASD 101," screening, referrals and assessments; cultural competency and diversity; treatment plan and progress note development; managing aggressive youth in therapeutic group homes; "MAP Team 101" training; youth suicide prevention (ASIST & safeTALK); Annual Mississippi School for Addiction Professionals; KIDS COUNT Conference; MS VR Conference; MS Gulf Coast Suicide Prevention Conference; Youth

Suicide Prevention for school safety officers; Annual Lookin' To The Future Conference; FASD Symposium; MASH Conference; Youth Court Judges and Referees Seminar; and MYPAC Training. By March 2010, Division of Children and Youth Services staff provided and/or facilitated the following training for providers of mental health services for children/youth: "FASD 101," screening, referrals and assessments; MAP Team 101, expansion and development; Therapeutic Group Home annual training; Annual MS School for Addiction Professionals; KIDS COUNT Conference; treatment plan and progress note development; youth suicide prevention; and, MS System of Care Initiatives.

Goal: To facilitate human resource development in addressing staffing/training needs of providers of mental health services to children with serious emotional disturbance and their families.

Objective: 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.

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, Community-based mental health system.

Brief name: Availability of technical assistance to DMH-certified programs

Indicator: Continued availability of technical assistance by DMH Division of Children and Youth staff to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.

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

Sources of

Information: Division of Children and Youth staffing report forms

Special

Issues: None

Significance: Division of Children/Youth Services will continue to offer technical assistance in the planning, implementing and/or improving services and programs for children and their families. This includes those programs that are identified in the DMH Minimum Standards as core or minimum services that must be available in all CMHC regions.

Funding: Federal, state and local funds

In FY 2009, the DMH Division of Children and Youth Services sponsored the *First Annual Gulf Coast Suicide Prevention Conference* (April 2009) and a cultural and linguistic workshop (April 2009 for all providers). In July 2009, DMH continued as a primary sponsor the *21st Annual*

Lookin' to the Future and the *Mississippi Permanency Partnership Network Conference*, conducted by Southern Christian Services. In September 2009, DMH also continued to sponsor the annual Mississippi Alliance for School Health Conference, with a pre-conference focusing on youth suicide prevention. By March 2010, DMH continued to serve as primary sponsor of the Annual Lookin' To The Future Conference conducted by Southern Christian Services for Children and Youth. DMH also sponsored the Annual KIDS COUNT Conference and 4 WRAP Around Trainings held by the University of Maryland. DMH will continue to sponsor the annual Mississippi Alliance for School Health Conference and the Annual FASD Symposium in September 2010.

Objective: 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.

Population: Children with Serious Emotional Disturbance

Criterion: Management Systems

Brief Name: Statewide Conferences and or trainings on the System of Care

Indicator: Provision of 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.

Measure: The number of statewide conferences and/or trainings sponsored or co-sponsored by the Division of Children & Youth Services.

PI Data Table C5.1	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Attendance at Statewide Institute or DMH-sponsored conference	796	885			
# of statewide conferences and/or training sessions sponsored or co-sponsored by DMH			Four	Four	Four

CYS					
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Source(s) of**Information:** Registration Forms for the Conferences; Final Conference Reports**Special****Issues:** None**Significance:** Training of service providers, both in the public community mental health system and across agencies that serve children and families, is a vital factor in facilitating both quality services, as well as interagency collaboration.**Funding:** CMHS funds

Technical assistance to residential treatment providers and state inpatient psychiatric hospitals also will continue to be provided or facilitated by DMH Division of Children and Youth Services staff, as requested/needed. Staff from the psychiatric units at the state hospitals will also continue to be invited to participate in monthly MAP team coordinators' meetings, at which additional technical assistance is available.

Training of Emergency Health Workers in the Area of Children's Mental Health**Mental Health Transformation: Workforce Development in Provision of Evidence-Based Practices (NFC Goals 5.3 and 5.4)****Mississippi Trauma Recovery for Youth (TRY) Project**

A grant for the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), began in October, 2003. The Director of the DMH Division of Children and Youth Services served in an advisory role to the project. 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), which works to develop and disseminate effective evidence-based treatments for child trauma; collect data for systematic study; and, help to educate professionals and the public about the effects of trauma on children. The goal of the NCTSN is to improve the quality, effectiveness, provision and availability of therapeutic services

delivered to all children and adolescents experiencing traumatic events. In working toward NCTSN's overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey –School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Mississippi has allocated part of its increase to the FY 2007 CMHS Block (\$52,511) to expand training in the evidence-based practice of trauma-focused cognitive behavioral therapy, building on “lessons learned” through the four-year Mississippi Trauma Recovery for Youth (TRY) project. The first Learning Collaborative effort provided training in the evidence-based practice of trauma-focused cognitive behavior therapy for a core group of mental health therapists and their supervisors at Gulf Coast Mental Health Center (Region 13 CMHC) from October 2006 through April 2007.

Funding from the FY 2008 CMHS Block Grant award will continue to be provided to Catholic Charities, Inc. to continue and expand the training to include additional clinical staff in community mental health programs. This national collaborative learning model has become a part of an approach for implementing an evidence-based practice at the community level in Mississippi, beginning with implementation of trauma-informed services for youth.

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 project is designed so that clinical management information can be integrated into the overall quality management program at the direct service and administrative levels. In FY 2009, the Mississippi Trauma Recovery for Youth (TRY) Project had the third Learning Collaborative for therapists in the south and central areas of the state; this Collaborative had been attended by 78 therapists and clinicians and by Learning Session II, had resulted in 121 children/youth receiving trauma-focused cognitive behavior therapy (TF-CBT). Each Collaborative involves supervisory staff in three, two-day Learning Sessions and in monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT. By March 2010, the Mississippi Trauma Recovery for Youth (TRY) Project began a Learning Collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) with four CMHC regions and staff from Specialized Treatment Facility.

Goal: To facilitate implementation of evidence-based practices for enhancing trauma-informed care.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Evidence-based practice training

Indicator: Provision of training for additional clinical staff in the evidence-based practice of trauma-focused cognitive behavior therapy through the learning collaborative model.

Measure: The number of additional community mental health services staff who complete training in trauma-focused cognitive behavioral therapy (50)

Mental Health Transformation PI Data Table	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Additional community mental health services staff trained in TF-CBT	130	83 Baseline	78	65	50

Implementation of the objective to provide training for CMHC staff in providing pre-evaluation screening for individuals being considered for civil commitment in the Adult Services Plan under Criterion #5 is applicable to CMHC staff providing pre-evaluation screening for adolescents being considered for civil commitment.

Initiatives Related to Children in Crisis in Schools

Additionally, as described under Criterion #1, Region 3 CMHC receives a specialized crisis intervention grant that helps support therapists in schools in that region. Also, Region 8 CMHC, through funding from DMH, provides therapeutic nurses in all four counties it serves and additionally, provides crisis case managers in Rankin County.

Other Initiatives for Training of Emergency Services Personnel

The DMH Division of Children and Youth Services will continue collaboration with the DMH Division of Community Services, which coordinates the Law Enforcement Task Force, to review the curricula used for law enforcement training for adequacy in addressing issues related to youth who might be encountered in a mental health crisis. Division staff will participate and/or support other efforts of the task force to assist or advise other agencies with responsibility for training emergency services personnel as requested. (The Department of Mental Health Minimum Standards for adults require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH.) Information on training offered by local providers regarding crisis management/intervention will continue to be reviewed.

Case Manager Training

In FY 2009, seven case management orientation sessions had been conducted and 180 case managers were trained. Training and technical assistance for new case managers, as well as review sessions for existing case management staff, will continue to be available from DMH Division of Children and Youth staff, upon request from CMHCs. Technical assistance, orientation and support for case managers are also available at the local level through existing staff at the CMHCs. By March 2010, two more case management orientation sessions were held, and Division of Children and Youth Services staff participated in both sessions. Additionally, as described in the following section on the certification/licensure program, the Department of Mental Health has also developed a certification program for case managers. DMH is drafting updated *Rules and Regulations for the Case Management Certification Program* and intends to pilot an online self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program; therefore, the following objective is being deleted. Providing the case management training program online will provide cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area.

Mental Health Therapist Certification and Licensure Program

The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master's level or above mental health staff members who are employed within Mississippi's state mental health system and who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist Exam and corresponding study guide was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 continuing education (CE) hours of mental health-related training over a two-year period in order to meet biennial renewal requirements. (*Note: the Mental Health Therapist licensure level is no longer available to new individuals, effective January 2009; however, individuals who achieved this level prior to its discontinuance are able to maintain it as long as they continue to meet the renewal requirements.)

Licensed Department of Mental Health (DMH) Administrator Program

The Mental Health Administrators program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master's level or above individuals who hold positions as the top-level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Once an individual enters the Program as a Program Participant, he/she must complete a program of Independent Study/Training to obtain licensure. Two Independent Study/Training Options are currently available: Option One-successful completion of the Mississippi Certified Public Manager program and a series of written examinations based on

Mississippi rules/regulations/standards and Option Two-successful completion of the Mississippi Certified Public Manager program and completion of the Department of Mental Health's leadership development program, Focus. After one of these Independent Study/Training options has been met, Program Participants are issued licensure. Once licensed, each individual is expected to accrue at least 40 contact hours of continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification Professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor's level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of Provisional Certification and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, PLACE made a number of changes:

- Began conversion of credentialing information and application forms to a web-based and/or email format. Therefore, PLACE staff no longer track how many application booklets are mailed out.
- Converted the previously required three Mental Health workshops and exams into one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. PLACE provided study materials to applicable programs.
- Changed the Independent Study/Training component for the Licensed DMH Administrator program to offer two options for Program Participants. Within the "exam option," the requirement was changed from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- Changed the training requirement for the Case Management program from three workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.
- Discontinued requiring CEs to move from provisional to full certification or licensure. CEs are only required to renew.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Licensed DMH Administrator Program and the Case Management Certification Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report continuing education hours when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of

the number of individuals in the process of pursuing ongoing in-service/training.

Objective:	To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Licensed DMH Administrator and Case Management Credentialing Program.
Population:	Children with Serious Emotional Disturbances
Criterion:	Management Systems
Brief Name:	Number of DMH-certified/credentialed staff
Indicator:	The number of individuals who hold a credential in the Mental Health Therapist program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE); the number of Program Participants and those holding licensure in the Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.
Measure:	The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees in the Licensed DMH Administrator program; the number of individuals who hold a credential in the Case Management Professional program. (Note: This measure includes individuals whose credentials have lapsed/expired.)
Source(s) of Information:	DMH/PLACE database; PLACE staff
Special Issues:	None
Significance:	Existing certification/licensure programs implemented by the Department of Mental Health were authorized by the MS State Legislature and approved by the Governor in 1996 and 1997.
Funding:	State funds

The number of individuals who hold a credential in the Mental Health Therapist program, the number of individuals who are Participants in the Licensed DMH Administrator program, and, the number of individuals who hold a credential in the Case Management Professional Program projected for FY 2011 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Mental Health Therapists (all levels)	1,733	1,959	2,161	2,175	
Mental Health Administrators (all levels)	121	122	126	125	
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	–	–	-		–
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	367	629/758	607	845	
Number of individuals who hold a credential in the Mental Health Therapist Program					1,275
Number of individuals how are Participants or who hold a credential in the Licensed DMH Administrator Program					97
Number of individuals who hold a credential in the Case Management Professional Program					100

Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in FY 2008, with 14 CMHCs and eight nonprofit programs reporting various training linkages pertaining to children's mental health with state universities and/or state community colleges, as well as private colleges. Areas of training/disciplines represented included: nursing, psychology, social work, psychiatry, (including child psychiatry), sociology, art therapy, social science, community counseling, education, school counseling, rehabilitation counseling, family and human development, public policy and administration, family studies, marriage and family therapy, public health, industrial counseling, educational psychology, criminal justice and human services. Additionally, the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) has integrated the child psychiatry fellowship program at UMMC with Mississippi State Hospital's Oak Circle Center staff and facilities.

Telepsychiatry Project

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 early August 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; they expect to have all community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service linked with 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 will also use the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). In addition, the Department of Psychiatry is looking into ways of sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

Information Management Systems Development

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 national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the DMH has applied for and received three, Mental Health Data Infrastructure Grants (MH-DIG) from the CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.

As mentioned, 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 contained in the URS tables. DMH submitted the following URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16(some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, 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 to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2011, efforts will continue to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan-related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers' local systems have been problematic in state-level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH - DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined 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. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children's services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser based system for data entry from these organizations.

The DMH Division of Information Systems and Division of Planning staff will continue to participate in CMHS conference calls and national meetings, held regularly to discuss the development of the URS data tables. DMH staff also will communicate regularly with the community mental health centers'/other providers' data managers as progress on development of the URS data tables continues. DMH Division of Information Systems and Division of Planning staff will also continue work with programmatic staff at the state level in the Bureau of Mental Health and at the local provider level to coordinate development of state plan reporting, including National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the *Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2008-FY 2010)*, which will enable the Mississippi Department of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts for the Uniform Reporting System measures, including the National Outcome Measures as required for the CMHS Block Grant program, to identify trends in services and outcomes, and increase the involvement of stakeholders in planning. The goals of the proposed project are to: (1) Refine the central data repository for public mental health system data; (2) Refine the process for collection

and reporting of information from consumer and family satisfaction surveys; (3) Improve data quality assurance systems; and (4) Increase accessibility and use of URS/NOMs measures and other mental health system data by the Mississippi State Mental Health Planning Council, DMH staff and other stakeholders involved in planning and system improvement activities. If its application for another three years of funding for the data infrastructure project is approved, DMH will pursue project plans to refine and implement a strategic plan for reporting client-level data for the National Outcome Measures targeted by CMHS, for refining infrastructure and processes for data collection and reporting, as well as for improving data integrity. Through continued data infrastructure development, quality assurance and technical assistance activities described in this proposal, the integrity and completeness of timely, detailed data to support measures for the Uniform Reporting System (URS) tables, including the National Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well as integration of the measures with other quality assurance information, will facilitate state planning and performance improvements across the system of services and supports for individuals with mental illness and their families.

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

Objective: Continue implementation of uniform data standards and common data systems

Population: Children with Serious Emotional Disturbance

Criterion: Management Systems

Brief Name: Implementation of uniform data reporting across community mental health programs.

Indicators/Strategies:

- 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.

Measure: Progress on tasks specified in the Indicator.

Special

Issues: As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

Significance: Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

Funding: State funds, Federal funds

**Projected Expenditures of Center for Mental Health Services Block Grant
Funds for Children's Community Mental Health Services
by Type of Service for FY 2011**

<u>Service</u>	<u>Projected Expenditures</u>
Intensive Crisis Intervention	168,775
Specialized/Multi-Disciplinary Sexual Abuse Intervention	25,039
Community Residential Therapeutic Group Homes	225,722
Therapeutic Foster Care	30,000
Crisis Intervention/Response Models	466,192
Respite	45,741
Multidisciplinary Assessment & Planning Teams (including State-level Case Review Team)	402,892
Therapeutic Nursing Services	90,000
Peer Monitoring	17,424
Training/Education/Staff Development	77,511
TOTAL	\$1,549,296

**Projected Allocation of FY 2011 CMHS Block Grant Funds
For Children's Services by Region/Provider**

<u>Providers</u>	<u>Projected Allocation</u>
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley Interim Executive Director (MAP Team flexible funds)	\$15,357
Communicare 152 Highway 7 South Oxford, Mississippi 38655 Carole B. Haney, Acting Executive Director (MAP Team flexible funds)	8,000
Region III Mental Health Center 2434 S. Eason Blvd. Tupelo, MS 38801 Robert J. Smith, Executive Director (Intensive Crisis Intervention; MAP Team flexible funds)	38,565
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)	168,677
Delta Community Mental Health Services 1654 East Union St. Greenville, MS 38704 Richard Duggin, Executive Director (MAP Team flexible funds)	10,000
Life Help P.O. Box 1505 Greenwood, MS 38935 Madolyn Smith, Executive Director (MAP Team flexible funds)	17,857

Community Counseling Services P. O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director (Crisis Intervention/Emergency Response, and MAP Team flexible funding)	89,159
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director (Crisis intervention/emergency response, MAP Team flexible funding)	112,745
Weems Community Mental Health Center P.O. Box 4378 Meridian, MS 39304 Maurice Kahlmus, Executive Director (MAP Team flexible funding)	15,357
Catholic Charities, Inc., Natchez (Region 11) 200 N. Congress, Suite 100 Jackson, MS 39201 Greg Patin, Executive Director (MAP Team flexible funding)	10,357
Southwest MS Mental Health Complex P.O. Box 768 McComb, MS 39649-0768 Steve Ellis, Ph.D., Executive Director (MAP Team flexible funding, Pike County)	4,000
Pine Belt Mental Healthcare Resources P.O. Drawer 1030 Hattiesburg, MS 39401 Jerry Mayo, Executive Director (MAP Team flexible funding)	20,357
Gulf Coast Mental Health Center 1600 Broad Avenue Gulfport, MS 39501-3603 Jeffrey L. Bennett, Executive Director (Intensive Crisis Intervention, MAP Team flexible funding)	43,528

Singing River Services 101-A Industrial Park Road Lucedale, MS 39452 Sherman Blackwell, II, Executive Director (MAP Team flexible funding)	15,357
Warren-Yazoo Mental Health Services P. O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director (Intensive Case Management and MAP Team flexible funding)	70,357
Catholic Charities, Inc. 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)	365,398
Gulf Coast Women's Center P. O. Box 333 Biloxi, MS 39533 Sandra Morrison, Director (Intensive Crisis Intervention)	30,000
Mississippi Children's Home Society and CARES Center P.O. Box 1078 Jackson, MS 39215-1078 Christopher Cherney, CEO (Therapeutic Group Home)	125,722
MS Families As Allies for Children's Mental Health, Inc. 5166 Keele St., Bldg. A Jackson, MS 39206 Wendy Mahoney, 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)	221,040
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)	120,000

Vicksburg Family Development Service
P. O. Box 64
Vicksburg, MS 39180
Kay Lee, Director
(Sexual Abuse Intervention) 25,039

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) 17,424
5,000

TOTAL \$1,549,296

Note: A total of \$187,722 (5% of the total amended award to be spent on services in FY 2011) will be used by the Mississippi Department of Mental Health for administration. It is projected that \$84,231 will be spent for administrative expenses related to children’s community mental health services.

Table C. Mental Health Block Grant Funding for Transformation Activities

Transformation Activity	Column 1	Column 2
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the actual or estimated amount MHBG funding that will be used to support this transformation goal in FY 2011
Goal 1: Americans understand that mental health is essential to overall health.		
Goal 2: Mental health care is consumer and family driven.	X	\$466,057
Goal 3: Disparities in mental health services are eliminated.	X	\$ 90,000
Goal 4: Early mental health screening, assessment, and referral to services are common practice.	X	\$417,696
Goal 5: Excellent mental health care is delivered and programs are evaluated.	X	\$107,511
Goal 6: technology is used to access mental health care and information.		

Goal II: Mental health care is consumer and family driven. Programs and/or services supported with CMHS Block Grant funds that are family-driven include respite services (\$45,741), which are coordinated and provided through Mississippi Families As Allies for Children’s Mental Health, Inc.; Making a Plan (MAP) Team activities (\$402,892), which involve family members in a state-level and local interagency teams that coordinate services and individualized planning for youth with serious emotional disturbances who have complex needs; and, peer review monitoring activities (\$17,424), which include family members with professionals in on-site program monitoring. (Note: Peer monitoring also addresses Goal V.)

Goal III: Disparities in mental health are eliminated. CMHS Block Grant funds (\$90,000) are used to support provision of therapeutic nursing services provided in school-based programs in two community mental health regions. Providing services through school-based sites is a major strategy in increasing access in rural areas. (Provision of therapeutic nursing services in school-based programs also addresses Goals I and IV.)

Goal IV: Early mental health screening, assessment and referral services are common practice. Crisis intervention programs (\$266,935) and one sexual abuse intervention program (\$25,039) supported with CMHS Block Grant funds (some of which are also school-based) all emphasize early identification, assessment, referral and treatment. CMHS Block Grant funding (\$125,722) also supports the provision of community-based residential treatment services for youth with co-occurring disorders of serious emotional disturbance and substance use/abuse.

Goal V: Excellent mental health care is delivered and programs are evaluated. CMHS Block Grant funds are used to support implementation of evidence-based practices, including the provision of therapeutic foster care services (\$30,000) and training in trauma-focused cognitive behavior therapy (\$52,511). Other workforce development activities are supported through CMHS Block Grant funds (\$25,000), including a statewide annual conference for children's mental health service providers. Topics addressed at this conference also relate to other Transformation Goals (e.g., cultural competency training would also address Goal III).

Note: Activities that address **Goal I: Americans understand that mental health is essential to overall health**, such as a statewide anti-stigma campaign and a youth suicide prevention initiative, are supported with state and/or other federal funds.

b) FY 2011 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SERIOUS MENTAL ILLNESS

Criterion 1: Comprehensive Community Based Mental Health Systems - The plan-

- **Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.**
- **Describes available services and resources in a comprehensive system of care. This consists of services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services for individuals diagnosed with both mental illness and substance abuse.**

Organizational Structure and Development of the System of Care

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. As further discussed under Criterion #4 that follows, these centers operate regional or satellite offices/services in 81 of the 82 counties. 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 who are mentally ill) 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. The redesign of crisis stabilization unit services is described in the section that follows on Activities to Reduce Hospitalization.

In FY 2009, House Bill 897 called for the establishment of a Joint Legislative Study Committee and allowed for formation of an advisory council to the study committee, both of which were formed and began work last year. The committee was charged with studying and making recommendations for improving the mental health system and with making recommendations to the Legislature, including any recommended legislation by December 1, 2009. Senate Bill 2645, passed in the 2010 legislative session, extended the Legislative Mental Health Study Committee and added the disparity of services across community mental health regions, ongoing and long-term financing, and organizational structure of the community mental health system to topics the study committee will examine.

Federal and State Resources

The FY 2011 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2010 Session. Also included under Criterion #5 in the Children's Plan and in the Adult Plan are objectives to request additional state funds for the 2012 fiscal year. Changes indicated under this criterion also reflect an increase to FY 2010 (current year) federal CMHS Block Grant funds. 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 (such as PATH funding for specialized programs for homeless persons). The DMH also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently, administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) If SSBG funding, which totals \$1.2 million for mental health services for adults and children, is no longer available in FY 2011, modifications to the plan may be required. The DMH also 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 the past nine 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. In FY 2011, projections are that between \$24 and \$32 million will be needed for match on CMHC Medicaid payments; the higher amount will be needed if the enhanced federal share of Medicaid under ARRA is not extended until June 30, 2011.

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.

Sources listed under the heading of "Funding" within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under "Funding" does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited. In FY 2010, DMH received an increase in CMHS Block grant funds in the amount of \$11, 413. Of this increase, \$10,870 will be utilized to support the Mississippi Coordinated Transportation Coalition and DMH's Transformation Transfer Initiative (TTI) efforts in providing transportation to individuals with disabilities. The funds will give grants to transportation service providers to provide transportation to individuals with serious mental illness to work, recreation and other activities for community inclusion. The remainder of the increase (\$543) will be spent on administrative costs.

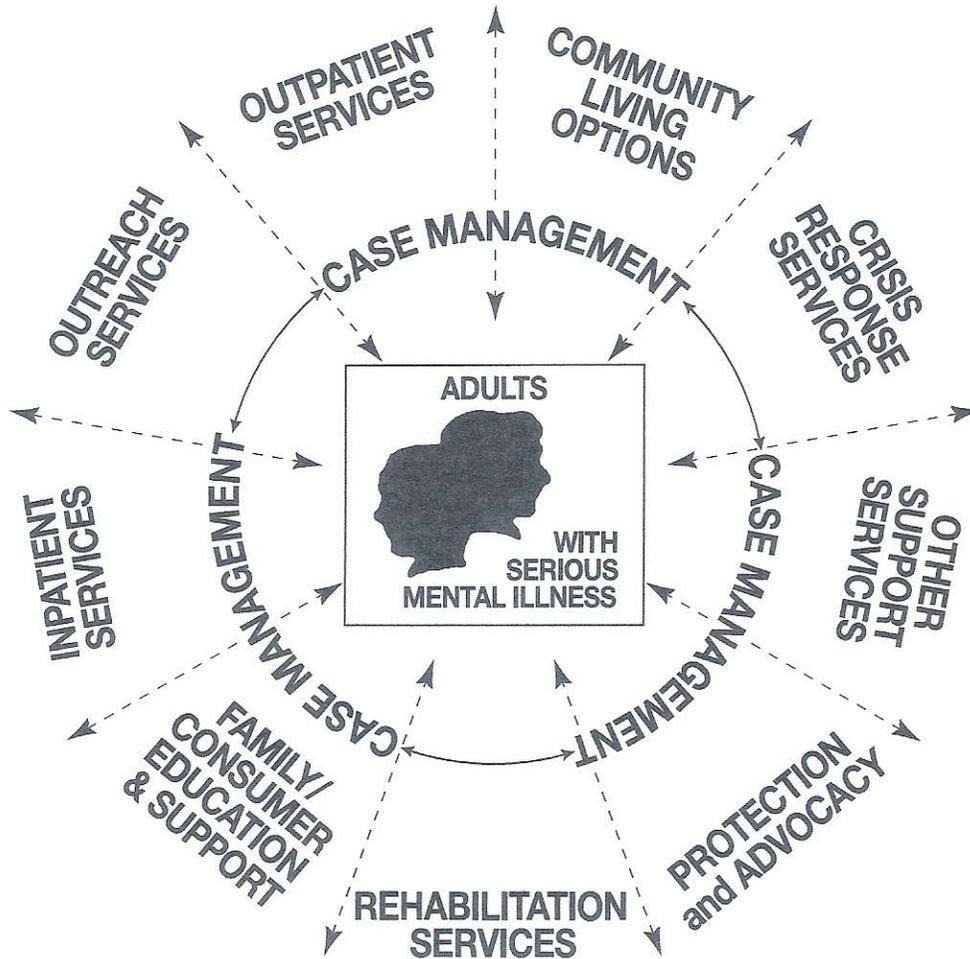
Ideal System Model

The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness (next page) 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. Consistent with an initial 2006 Planning Council recommendation, 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

Systems Development Initiatives

Other Cooperative Initiatives with the Division of Medicaid

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 Center 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.

Mental Health Transformation Activity: Involving Consumers Fully in Orienting the Mental Health System toward Recovery (NFC Goals 2.1 and 2.2)

Mental Health Transformation Activity: Individualized Treatment/Service Planning (NFC Goal 2.1)

Person-centered Planning

The *Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services* will continue to 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 30 days of admission for outpatient services and within seven days of admission for all residential treatment services. During the annual site/certification visits, it is determined whether or not the assessments are completed.

The DMH Division of Community Services is hopeful that individuals receiving services, as well as direct service and administrative staff from the community mental health regions, will adopt the philosophy provide more person-directed, recovery-oriented services for people in the system of care. The Division of Community Services will continue to review existing service standards for potential revisions that would support sustaining of 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 minimum standards for operation of community mental health programs, in which DMH plans to include that person centered/directed philosophy.

Quality Improvement System Development

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 more recently, in the agency's Strategic Plan, the Mississippi Department of Mental Health continues work to

improve its system of program evaluation and planning, a key focus of which is further development of its data infrastructure and information management systems, described in more detail under Criterion 5. As noted throughout the plan, 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).

Mental Health Transformation Activity: Involving Consumers Fully in Orienting the Mental Health System toward Recovery (NFC Goal 2.2)

Peer Review

In addition to monitoring community mental health service providers' compliance with minimum standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in adult community mental health services, consumers, families and other stakeholders. Based on feedback from satisfaction surveys in FY 2008, revisions were made to improve the peer review process for FY 2009. Peer review visits FY 2009 involved a smaller, more focused team of one consumer representative, one family member and one stakeholder. During the review, a sample of each type of program is visited. The Division developed a manual/guide for Peer Reviewers that describes available services by region, and core services; thumbnail images of service locations were placed next to addresses. A pre-conference visit is also held with service providers, in addition to the exit conference at the close of the visit. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person-driven, evidence-based, recovery-oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011.

Goal: To continue development of the program evaluation system to promote accountability and to improve quality of care in community mental health services.

Objective: 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).

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation of peer review

Indicator: A Recovery Self Assessment (Assessment) tool developed to measure transformation from a traditional mental health service system to a recovery-oriented system of care. The primary goal of the Assessment is to provide a tool that assists stakeholders to consistently track transformation activities in accordance with the Department of Mental Health's vision of developing a person driven, recovery oriented system of care.

Measure: Development of a Recovery Self Assessment tool to measure movement from the traditional model to a recovery oriented system of care.

Source(s) of

Information: Peer review reports, which are mailed to the Community Mental Health Centers and the Division of Community Services at East MS State Hospital and MS State Hospital.

Special

Issues: Peer monitors include family members, consumers and/or professional staff. Typically, peer review teams conduct visits in conjunction with DMH standards monitoring visits. The number of peer review visits conducted within a given time period can vary, which is related to variations in the certification visit schedule. The teams will conduct an assessment with the programs utilizing the Recovery Self Assessment guide after a self assessment has been completed by the community mental health center, state hospital, and/or private program.

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Peer review site visits provide additional technical assistance opportunities for community programs from other providers in the state on a regular basis. The Recovery Self Assessment tools will allow the Department of Mental Health to assess how the community mental health centers and state hospitals identify strengths that already exist and acknowledge areas that require enhancement and further development..

Funding: CMHS Block Grant Funds

Consumer Satisfaction Survey

National Outcome Measure: Client Perception of Care – Outcomes of Services Domain (URS Basic Table 11)

Goal: To improve the outcomes of community-based mental health services.

Target: Maintain percentage of adults with serious mental illness who respond positively about outcomes.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Indicator: Adults with serious mental illness responding to a satisfaction survey who respond positively about outcomes.

Measure: Percentage of adults who respond to the survey who respond positively about outcomes

Sources of

Information: Results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH).

Special

Issues: Administration of a state variation of the *MHSIP Consumer Satisfaction Survey* using a

revised methodology to produce statewide results began in FY 2004. With consultation and approval from CMHS, the MHSIP was not administered in 2005 because of a delay in start-up (due to a change in staff working on the project) and state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. DMH has worked with the University of Mississippi Medical Center, Center for Health Informatics and Patient Safety, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* in FY 2006 - FY 2010 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region beginning with the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions.

Significance: Improving the outcomes of services from the perspective of individuals receiving services is a key indicator in assessing progress on other goals designed to support recovery-oriented systems change.

Action Plan: The Division of Community Services and the Division of Family and Consumer Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care and dissemination of evidence-based practices, e.g., continued availability of training on person-centered planning, development of an education campaign about recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change, and the initiative to provide training on evidence-based, integrated treatment for persons with co-occurring disorders.

Satisfaction Survey of Individuals Receiving Services

National Outcome Measure: Client Perception of Care: Outcomes of Services (URS Basic Table 11)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 Target	FY 2011 Target
Performance Indicator					
% Reporting Positively about Outcomes	71%	71%	74%	77%	72.5%
Numerator	491 positive responses	447 positive responses	1071 positive responses	476 positive responses	
Denominator	690 responses	628 responses	1453 responses	615 responses	

* As recommended by CMHS, starting in FY 2006, the official version of the MHSIP survey is being used. The FY 2006 MHSIP and subsequent surveys also included additional items recommended by CMHS, which may also affect response rates; therefore, a new baseline was established.

Results from the *MHSIP Consumer Satisfaction Survey* indicate perception of care in all major domains of service, in addition to the National Outcome Measure on outcomes of services (described above). These domains include outcomes, access, quality and appropriateness, participation in treatment planning and general satisfaction with services and are indicated in the following table.

Satisfaction Survey of Individuals Receiving Services

National Outcome Measure: Client Perception of Care – Outcomes (URS Basic Table 11)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 Target	FY 2011 Target
Performance Indicator					
1. % Reporting Positively about Access	87%	89%	89%	88%	89%
Numerator	593 positive responses	564 positive responses	1332 positive responses	543 positive responses	
Denominator	679 responses	636 responses	1494 responses	617 responses	
2. % Reporting Positively about Quality and Appropriateness for Adults	88%	90%	91%	89%	90%
Numerator	599 positive responses	569 positive responses	1351 positive responses	549 positive responses	
Denominator	679 responses	635 responses	1491 responses	616 responses	
3. % Reporting Positively about Outcomes	71%	71%	74%	77%	72.5%
Numerator	491 positive responses	447 positive responses	1071 positive responses	476 positive responses	
Denominator	690 responses	628 responses	1453 responses	615 responses	
4. % Reporting on Participation in Treatment Planning	74%	76%	80%	76%	77%
Numerator	480 positive responses	480 positive responses	1158 positive responses	461 positive responses	
Denominator	657 responses	631 responses	1451 responses	608 responses	
5. % Reporting	90%	90%	91%	89%	91%

Positively about General Satisfaction with Services					
Numerator	603 positive responses	574 positive responses	1366 positive responses	549 positive responses	
Denominator	673 responses	637 responses	1493 responses	615 responses	

Mental Health Transformation Activity: Implementation of Consumer Information and Grievance Reporting System (NFC Goal 2.5)

The Office of Constituency Services 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. Through mid-FY 2010, OCS has received 6497 calls on the Suicide Prevention Lifeline. 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 Minimum Standards for Community Mental Health/Mental Retardation Services* 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 minimum standards monitored by OCS. These modules are available as requested by any DMH-certified program.

In FY 2010, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities).

Additionally, OCS continues to publish, distribute, and update the “Directory on Disk” program to all DMH facilities and community mental health centers, as well as DMH Central Office staff. This directory gives service providers access to basic program/ service information for over 2700 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the statewide database used for information and referral (approximately 45 new programs were added and over 344 individual programs’ information has been updated in FY 2010); this process is also ongoing.

Objective: 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.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Constituency Services Call Reports

Indicator: 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.

Measure: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports).

Source(s) of

Information: Data provided through the software, as calls to the OCS help line logged into the computer system.

Special

Issues: Dissemination of the directory on disk (a read only version containing program information) is being provided only to DMH-certified and funded providers who sign a use agreement to ensure preservation of accurate and current data.

Significance: The establishment of a toll-free grievance telephone reporting system for the receipt (and referral for investigation) of all complaints by clients of state and community mental health/retardation facilities is a provision of the Mental Health Reform Act of 1997. The concurrent development of a computerized current database to also provide callers with information and assistance facilitates access to services by individuals expands the availability of current and detailed statewide service information to community mental health centers.

Funding: State General Funds

Mental Health Services

Local Community Support Systems Planning

In 1993, a task force on community support developed requirements for each service of the ideal system of care that could be used as an outline for service providers to use to plan their local plans, referred to at that time as Community Support Programs (CSP). Since then, this outline, which has been modified somewhat over time, has been used for the program narrative outline required when service providers apply for CMHS block grant funds. These grants make available a portion of the CMHS Block Grant to community mental health centers to be used on a purchase-of-service basis for various services within the system of care.

Regional community mental health centers are required in their plans 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.

Mental Health Transformation Activities: Support for Culturally Competent Services (NFC Goal 3.1)

Multicultural Task Force

Mississippi has a significant minority population. According to 2000 U. S. Census figures, Mississippi has a population of 2,844,658, with an estimated 39% of its citizens identified as nonwhite. Of the total number of nonwhite individuals, approximately 94% are African-American. Additionally, as a largely rural state, there is a great need for cross-cultural awareness and sensitivity in outreach and mental health service delivery activities

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the 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. The task force membership was expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling was also helpful. There were 36 members on the task force during the development of the Cultural Competency Plan including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-Mississippi; Mental Health Association Director; Jackson State University, School of Social Work; Jackson State University, SMHART (Southern Institute for Mental Health Advocacy, Research and Training); Jackson-Hinds Community Health Center, Ellisville State School, Jackson Healthcare Center, Grant Consultant; and

Chairperson of the Mississippi State Mental Health Planning and Advisory Council. Currently, there are 17 active members on the task force. The Multicultural Task Force Strategic Map mission statement 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.” The definition of cultural competency chosen by the task force members is: “the acceptance, understanding and embracing of all cultures.” “Culture” refers to an integrated pattern of human behaviors that includes language, thoughts, communications, actions, customs, beliefs, values and institutions of all individuals. task force has developed the *Draft, Mississippi Department of Mental Health Proposed Plan for Cultural Competency*, and a subcommittee met to develop the Communication Continuum for Sharing the Cultural Competency State Plan. By mid-year in FY 2010, the Multicultural Task Force had met twice (in November, 2009 and April, 2010). The task force organized the statewide Day of Diversity that was held on October 13, 2009. An annual report of the task force’s activities was presented to the Planning Council on April 22, 2010.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Multicultural Task Force operation

Indicator: Continued meetings/activity by the Multicultural Task Force

Measure: The number of meetings of the Multicultural Task Force during FY 2011 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council, and the number of new members from other ethnic groups added to the Task Force.

Source(s) of

Information: Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) made.

Special

Issues: None

Significance: The establishment and ongoing functioning of the Multicultural Task Force have 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.

Funding: State funds

Cultural Competency Plan

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation Cultural Competency Workgroup

Indicator: Meeting/activity by the Cultural Competency Workgroup

Measure: The development of the committee and number of meetings

Source(s) of

Information: Minutes of the workgroup meetings

Special

Issues: None

Significance: The function of the workgroup is to guide the implementation of the Cultural Competency Plan.

Funding: State Funds

Local Provider Cultural Competence Assessment

In FY 2001, the Multicultural Task Force initiated planning for use of a cultural competence assessment instrument at the local level, with introductory information being provided to CMHCs regarding the potential piloting of such an assessment. 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. Since 2002, a cultural competence assessment recommended by the task force has been implemented by community mental health regions 1, 2, 3, 4, 6, 7, 8, 11, 14 and 15. Following these assessments, DMH staff has continued to offer and/or provide follow-up consultation to local providers in developing recommendations for action steps based on assessment results. 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. By August 2010, Region 2 completed the local cultural competency assessment; results will be discussed with the regional center staff by September 30, 2010.

Objective: 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.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Cultural competency pilot project expansion

Indicator: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project.

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

Source(s) of Information: Division of Community Services Activity Report

Special Issues: Participation in the project will be voluntary.

Significance: 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.

Funding: State and local funds

As of April 2010, an NCBI training session had been conducted for Mississippi Families As Allies for Children’s Mental Health, Inc. (April 23, 2010), which was attended by approximately 60 participants.

Goal: To provide appropriate, culturally sensitive services for minority populations.

Objective: To make training available to community services staff in cultural awareness and sensitivity.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Cultural diversity training availability, state level

Indicator: Availability of NCBI training sessions on cultural awareness and sensitivity.

Measure: The number of NCBI training sessions made available to service providers (Minimum of 3)

PI Data Table A1.4	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# of NCBI Training Sessions for service providers	5	4	6	3	3

Source(s) of Information: NCBI: MS Chapter Training Records

Special

Issues: The Multicultural Task Force will continue to explore ways to assess the impact of the NCBI training, including participants' next steps in encouraging or promoting diversity in the community. The number of training sessions provided depends on the number of requests for training received and availability of staff qualified to provide the training.

Significance: The State Plan calls for the operation of a Multicultural Task Force to address issues relevant to providing mental health services to minority populations in Mississippi, which has focused much of its efforts on training needs. Training has been provided to increase the cultural awareness and sensitivity of community services staff.

Funding: State and/or federal funds

Outpatient Services, a component of the ideal system, include diagnostic and treatment services in various treatment modalities for those persons requiring less intensive care than provided by inpatient services, including individuals with serious mental illness. Outpatient services include: individual, group, family, and multi-family group therapy and aftercare services, which are currently provided by all 15 CMHCs; medication evaluation and monitoring; emergency services and inpatient referral, part of the crisis response component of the ideal system, provided through the 15 regional CMHCs; family education/support and consumer education/support services, case management services, available to adults with serious mental illness and the Community Services Divisions of East MS State Hospital and MS State Hospital; pre-evaluation screening and civil commitment services and psychosocial rehabilitative services, which include clubhouse programs.

Mental Health Transformation Activities: Improving Consumer Access to Employment Services and Supports

Rehabilitation, Employment and Educational Services

Psychosocial rehabilitative services are therapeutic activity programs provided in the context of a therapeutic milieu in which consumers can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial rehabilitative services, which involve a continuum of services based on the level of need of the consumer, include psychosocial rehabilitation (clubhouse), day support, and acute partial hospitalization services, as well as psychosocial rehabilitation specialized for elderly persons.

Psychosocial Rehabilitation is a community support service for individuals with serious mental illness, which consists of a network of services that help them develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse refers to a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental support.

All CMHCs in the state provide psychosocial rehabilitation programs based on the clubhouse model. Principles of the clubhouse programs are:

- 1) to provide programs that enhance individuals' skill development;
 - 2) to improve employment opportunities for persons with psychiatric disabilities;
 - 3) to improve the capabilities and competence of persons with psychiatric disabilities...potential is emphasized over alleviating symptoms;
 - 4) to provide individuals the opportunity for active participation in their rehabilitation within an atmosphere in which things are done with the consumer and not to them;
 - 5) to promote positive expectations and respect for individuals, which are the essential ingredients of the program.
-

Availability and Improvement of Psychosocial Rehabilitation Programs

As of April 2010 there were 60 clubhouse sites operational statewide. There are four ICCD certified clubhouses in Mississippi: Region 5 (Greenville), Region 6 (Greenwood), Region 12 (Hattiesburg), and Region 9 (Jackson). Region 5 has been officially defined by ICCD as a Welcome Center. The ICCD Clubhouse in Greenville continues to provide a one week training program, which includes transitional employment to clubhouses in Mississippi. The DMH also continued to support Region 5 in maintaining a clubhouse thrift store in the community. In FY 2010, DMH continued to make available training/technical assistance targeted at improving implementation of the transitional employment component of the clubhouse rehabilitation program. Additionally, DMH made available funding to the development of training focused on transitional employment, which is part of the one week training Washington Square provides. Staff and clubhouse members from Washington Square continue to work with ICCD representatives to strengthen the transitional employment component of the training. The number of programs traveling to the training site has declined in past year primarily due to budget constraints. In FY 2010, the Director of the ICCD-certified clubhouse in Greenville provided technical assistance about ICCD certification to 13 individuals from Region 7, Community Counseling Services. Region 6 (LifeHelp) has submitted an application for ICCD certification for clubhouses located in Lexington and Indianola. The Opportunity Clubhouse, operated by the Division of Community Services at Mississippi State Hospital, is conducting a self-study for the ICCD certification. By mid – FY 2010, one representative from Region 12 (Pine Belt Mental Healthcare Resources) was scheduled to attend ICCD training in June 2010, and a group of individuals from Region 6 (LifeHelp) was scheduled to attend the training in July.

Note: The rehabilitation services and related activities addressed by the following goal will continue to be available, and the number of individuals receiving psychosocial rehabilitative services tracked; however, since some of these objectives represent maintenance activities, the specific goals/objectives are being deleted as part of edits to make the plan more succinct.

Goal: To provide rehabilitation services for adults with serious mental illness.

Drop-In Center

In 2010, the Mississippi Department of Mental Health continued to provide funding support to drop-in centers in Gulfport and in Corinth. By mid-FY 2010, the center in Gulfport had served 62 adults with serious mental illness, and the center in Corinth provided services to 30 adults with serious mental illness. DMH will not provide funding for the drop-in center in Corinth in FY 2011.

Objective: To make available funding to support one drop-in center for adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Drop-in center

Indicator: Availability of funding through DMH to help support one drop-in center.

Measure: The number of individuals served by the drop-in center will be tracked

Source(s) of

Information: Documentation of grant award on file at DMH; monthly cash requests.

Special

Issue(s): None

Significance: The drop-in center, in addition to providing services to individuals with serious mental illness in the Gulf Coast area, will also provide technical assistance to programs with existing or new drop in centers.

Funding: Federal and state.

Additionally, the day program for individuals at CMRC is based on a psychosocial model and focuses on transitioning individuals to a more independent setting in the community.

Clubhouse Coalition

A primary objective of a Clubhouse Coalition is to form alliances and to collaborate with other organizations and state agencies that work to improve services for individuals with mental illness (such as the Department of Rehabilitation Services, the National Alliance on Mental Illness and the Mental Health Association). The coalition will also include clubhouse coordinators from the 15 mental health regions.

Training in the Clubhouse Model

By mid-2010, one representative from Region 12 (Pine Belt Mental Healthcare Resources) was scheduled to attend ICCD training in June 2010, and a group of individuals from Region 6 (LifeHelp) was scheduled to attend the training in July.

National Outcome Measure: Evidence-Based Practice – Supported Employment (URS Developmental Table 16)

As in previous years, the DMH will continue to collect/report information on the number of individuals served in transitional employment programs, as defined by the state. DMH has continued work in FY

2010 to develop capacity to collect data for evidence-based practices. The federal definition of “supported employment” as an evidenced based practice as proposed in URS Developmental Table 16 has some components that are similar to the state definition of supported employment, but differs along some components. DMH will continue activities through its Data Infrastructure Grant (DIG) project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported employment. DMH is continuing work on development of capacity for collection of data for the National Outcome Measures on evidence-based practices with support from the CMHS Data Infrastructure (DIG) Quality Improvement grant.

National Outcome Measure: Increased/Retained Employment (URS Table 4); Individuals employed as a percent of those served in the community.

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

Target: The Division of Community Services will increase efforts to explore existing relationships with the Department of Rehabilitation Services, Vocational Rehabilitation as related to better utilizing existing resources for individuals with mental illness

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Number of persons served by the public community mental health system who are employed.

Measure: 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.

Sources of

Information: Aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 4: Profile of Adult Clients by Employment Status

Special

Issues: Finding jobs is a challenge in many parts of the state, especially in the current economic environment. (The moving 12-month average unemployment rate for the state as of was 10.4%, compared to 7.7% at approximately the same time last year (March, 2009) and compared to the national average unemployment rate for April 2010 of 9.7%). DMH continued work in FY 2010 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 4. DMH plans to pursue collection of data in the Optional table 4A in FY 2011 to gain additional information on employment status for individuals with mental illness, as potentially associated with diagnosis.

Significance: The issue of employment, along with the issues of housing and transportation, are interrelated and must be addressed as necessary components of individuals’ recovery, along with appropriate, evidence-based treatment, illness self-management and support,

including support for families.

Action Plan: The DMH Division of Community Services will continue to make available technical assistance on the transitional employment component of the clubhouse programs described previously in the State Plan, since some TEPs have transitioned into permanent, competitive employment. The Division of Community Services will increase efforts to explore existing relationships with the Department of Rehabilitation Services, Vocational Rehabilitation as related to better utilizing existing resources for individuals with mental illness, such as job discovery, job development, preparedness and job coaching activities. Initiatives that provide support for employment, such as the Transportation Coalition activities and efforts to address the need for more housing options described in the State Plan, will also be continued.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
Individuals employed as a percent of those served in the community	17.9%	17.5%	16.2%	17.7%	17.2%
Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)	9219	9541	9,437*	9286	
Denominator: # of persons employed + unemployed + not in labor force (excludes "not available" status)	51,451	54,473	58,176*	52,452	

Note: Final edits to 2009 URS Table 4 data (above) include a correction to remove data from hospital programs from the numerator and denominator; however, the overall percentage for the performance indicator in FY 2009 remained the same (16.2%).

Day Support is a psychosocial rehabilitative service that became available in FY 2002 for adults with serious mental illness. Day support, which is the least intensive psychosocial rehabilitative service, is a program of structured activities designed to support and enhance the role functioning of consumers who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Structured activities of the program are designed to maintain individuals in an

environment less restrictive than inpatient or therapeutic residential treatment; develop daily living, social and other therapeutic skills; promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills; provide assistance in maintaining and learning new skills that promote independence; develop interpersonal relationships that are safe and wanted by the individual to eliminate social isolation; and, to improve physical and emotional well-being. Day support programs include, at a minimum, social skills training, group therapy, individual therapy, training in the use of leisure time activities, and coping skills training. The program must provide individuals with opportunities for varied activities, active and passive, and for individuals to make choices about the activities in which they participate.

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. Program content can vary, depending on individual strengths and needs, but must include close observation/supervision and intensive support, with a focus on the reduction and/or elimination of acute symptoms. Acute partial hospitalization provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired.

Other Vocational Rehabilitation/Employment Services

DMH minimum standards require that transitional employment programs be available as part of clubhouse programs, which are available in all 15 CMHC regions. 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 can, 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 Director 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 ten 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. Examples of specific Vocational/Employment/Educational Services provided to adults with serious mental illness, in addition to or in conjunction with vocational rehabilitation services and consumer education programs (described in previous objectives) in FY 2009 included: resume writing assistance, interview skills training and job referrals, employment counseling, work activity, commercial licensure and driving training, safe food preparation and food service, vocational evaluation, transitional employment, job placement, community volunteer programs, GED prep and GED programs, literacy training programs, adult education programs, academic and vocational education, money management/budgeting training, nutrition education, parenting education, computer education, literacy programs, educational programs related to illness self-management, adult basic education, financial assistance for education, single parent/displaced homemaker services, community college coursework, education about safety issues and public transportation, independent living skills training, education about health living/nutrition, education about communicable diseases, leadership/advocacy skills training, functional living skills and income tax preparation.

The CMHCs, CMRC and the Community Services Divisions of the two larger state hospitals continued linkages with a variety of agencies in local communities that made these services available. Examples of individual agencies providing these types of support services in 2009 included: the MS Department of Rehabilitation Services, WIN Job Service, Alliance, MS Highway Safety Patrol, Mississippi Cooperative Extension Services, CARES of Mississippi, private staffing companies, Mississippi State Employment Security Commission, Goodwill Industries, the Salvation Army, Gaining Experience to Succeed (volunteer programs), Piggly Wiggly food stores, community colleges across the state, Job Corps, local literacy councils/programs, family and community resource centers, local public library, NAMI-MS, MS Department of Human Services, Boys and Girls clubs, area churches/faith-based organizations, universities, public school districts, county human resource offices, Recruitment and Training Program of Mississippi, county extension local vocational-technical centers, the United Way, Mental Health Association of the Capital Area, Inc., Disability Rights Mississippi, Inc., the City of Jackson, Mississippi Community Education Center, Institute of Disability Studies (University of Southern Mississippi) and the Mississippi Leadership Academy.

Mental Health Transformation Activity: Improving Access to Affordable Housing and Supports

In addition to effective treatment, illness self-management and support, the issues of housing, employment and transportation must be addressed as necessary components of individuals' recovery. The need for additional adequate and affordable housing for individuals with serious mental illness is a major issue challenging the system in Mississippi and most importantly, individuals' opportunities for full recovery. The availability of safe, affordable housing, as mentioned, is key to the success of system transformation efforts focused on diverting individuals from hospitalization or re-hospitalization and on diverting individuals from the criminal justice system. The Department of Mental Health's Ten-Year Strategic Plan included an objective to establish a Housing Task Force in Year 1. In FY 2010, the Division of Planning in the Bureau of Community Services, which had also been participating in the National Association of State Mental Health Program Directors (NASMHPD) Housing Task Force, began work to establish the task force, to network with potential

partners at the state and local level, and to seek specialized technical assistance to facilitate development of a strategic plan for housing for individuals with serious mental illness. The task force has held two meetings in FY 2010 (December 2009 and March 2010). The Mississippi Development Authority (MDA)'s representative on the Mississippi State Mental Health Planning and Advisory Council, who is a key staff person in development of the state's Five-Year Consolidated Plan for use of federal housing funds, has been very supportive of initial activities, as have other members of the Council, its Long Range Planning Committee and the Housing Task Force. Other important partners who have agreed to work on the housing planning initiative include the Mississippi Home Corporation, the University of Southern Mississippi, Institute of Disabilities Studies (IDS), USDA, Office of Rural Development, and individuals who serve on the three continua of care entities in the state; efforts to expand partnerships at the state and local levels are ongoing. On the recommendation of Council members who attended the SAMHSA-sponsored Olmstead Conference in the fall of 2009, DMH applied for technical assistance that was available from the Center for Mental Health Services (CMHS) to support states in their transformation efforts to achieve full community integration of adults with serious mental illnesses and children with serious emotional disturbance. The Bazelon Center for Mental Health Law, in collaboration with Magna Systems, the technical assistance subcontractor for this federal initiative, worked with state staff to address DMH's request for technical assistance on supportive housing, which resulted in a one-day on-site visit by the Technical Assistance Collaborative (TAC) in January 2010. Staff from TAC met with members of the Housing Task Force and some additional DMH and community mental health program staff to provide an overview of the best practice model of Permanent Supportive Housing (PSH) model; descriptions of models for service linkage with PSH units; examples of PSH in other states/local areas; overview of statistics on need and emerging trends/policy/funding changes currently under review/discussion at the national level; and, a question/answer group session. TAC staff also met with DMH staff to address specific operational questions, given current system challenges and changes, and to provide assistance in thinking about strategies and "next steps."

The MS DMH applied for and received Transformation Transfer Initiative (TTI) funding from the Center for Mental Health Services, Substance Abuse Mental Health Services Administration; housing was one of three transformation areas addressed in the application. The TTI is funding assistance from two consulting entities with expertise in planning housing and housing-related services (Simons Consulting, LLC and the Technical Assistance Collaborative, Inc.) to support the DMH staff and the Housing Task Force in development of a statewide strategic plan for housing for individuals served by the public mental health system. This strategic planning initiative, which is underway and projected to continue into FY 2011, will address the following major goals: (1) needs assessment to research current housing stock by location and level of support; (2) gap analysis to identify priority system issues, refine strategies for development of housing and housing-related supports and to address consumer and family input on need and preferences; (3) building housing partnerships at the state and local levels, including facilitating work to identify relevant policy, regulatory or process issues and to develop collaborative strategies to address those issues; (4) assessment and planning of service system models, reimbursement mechanisms and capacity to contribute to housing and service system re-design models; and, (5) development of additional funding mechanisms, focusing on maximizing mainstream housing affordability opportunities, on designing a bridge subsidy program and readiness for use of potential new federal housing resources. In FY 2010, the DMH was approved for the SAMHSA-supported SSI/SSDI Outreach, Access and Recovery (SOAR) Technical Assistance Initiative, which will be administered through the Projects for Assistance in Transition from Homelessness (PATH) program in the Department of Mental Health and will contribute to the success of the strategic planning initiative for housing. (See also Criterion 4.)

The DMH offers grants to community mental health centers, private providers, and the Community Services Divisions of two of its state hospitals to help support array of community-based housing options for persons with serious mental illness. These housing options currently include:

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. As of mid-FY 2010, the Department of Mental Health had certified 26 group homes for adults with serious mental illness, with a total capacity of 325 as follows: Region 2, 8 beds; Region 3, 29 beds; Region 5, 30 beds, Region 6, 24 beds; Region 12, 31 beds, Region 13, 24 beds; Region 15, 27 beds; East MS State Hospital, Division of Community Services, 77 beds; Mississippi State Hospital, Division of Community Services, 27 beds; and, Central MS Residential Center, 48 beds.

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 hospitalization. Emphasis is placed on achieving stabilization, on developing and refining social and basic living skills, and acquiring other coping skills. In FY 2010, DMH had certified three residential transitional programs in the state with a total of 34 beds, two of which are in the regions near the two larger state psychiatric hospitals (EMSH Community Services operated 10 beds (Enterprise), and MSH Community Services operated eight beds in Jackson), with the third in Greenwood (16 beds).

Supervised housing is currently defined as 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. Supervised housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day, consumers may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities. The persons living in the supervised housing service must be registered consumers of the provider program who have been determined to have a serious mental illness. As of March 2010, DMH had certified 14 supervised housing programs in six CMHC regions: Region 5 (capacity 30), Region 6 (capacity 44), Region 7 (capacity 51), Region 8 (capacity 8), Region 14 (capacity 12) and Region 15 (capacity 8); MSH Community Services had a capacity of 8 supervised housing beds.

Supported living is currently defined as programs designed to provide individuals some assistance while allowing them to maintain an independent residential arrangement. Supported living programs differ from “supervised apartments” in that supported living programs may have little or no involvement from the center in operation of the residence, support staff may not live in close proximity to the residence and contacts with consumers occur on a weekly or less frequent basis.

Other Housing Options Community mental health service providers also continued efforts at the local level to access and/or expand community housing options for individuals with serious mental illness. Region 4 CMHC has been involved with four HUD-funded apartment projects, located in Corinth, Iuka, Ripley and Booneville, with a total of 18 apartments per site. Region 15 has been involved in a 17- unit project-in Vicksburg. In Region 6, 14 HUD apartments serve 16 individuals (two of the apartments are two-bedroom units); NAMI-MS is collaborating on a HUD project planned for Lexington, which is also in Region 6.

Housing Options with DMH funding support	Programs	Beds	Total Served as of mid-FY 2010
Group Homes	26*	277*	277*
Halfway Houses	3	34	39
Supervised Housing	14	161	172

*Does not include 48 group home beds operated by CMRC.

In an effort to consolidate and refine the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/IDD Services*, DMH examined standards for services provided to different populations that could be combined where they were addressed separately in the past; therefore, the standards for community living across target populations were examined and it is projected that draft revisions will address overlap in services standards and/or definitions across groups.

National Outcome Measure: Evidence-Based Practice – Supported Housing (URS Developmental Table 16)

DMH continued work in FY 2010 to develop capacity to collect data for evidence-based practices by the FY 2011 timeline. The federal definition of “supported housing” as an evidenced based practice as proposed in URS Developmental Table 16 is similar to what is referred to in Mississippi as “supervised living.” DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported housing. DMH is continuing work on developing capacity for collection of information, for reporting evidence-based practices (such as supported housing) and for improving data integrity for the National Outcome Measures, with support from the CMHS Data Infrastructure Grant (DIG) for Quality Improvement.

National Outcome Measure: Increased Stability in Housing (URS Table 15); Percent of Adults Reported to be Homeless/in Shelters

Goal: To continue support and funding for existing programs providing outreach and coordination of services to individuals with serious mental illness who are homeless/potentially homeless.

Target: To continue support and funding for existing programs for individuals with serious mental illness who are homeless/potentially homeless.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Indicator: Number of adults served in the public community mental health system, reported as homeless/in shelters

Measure: Number of adults reported in homeless/in shelters as a percentage of adults served in the public community mental health system

Sources of

Information: Division of Community Services Program grant reports and DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile

Special

Issues:

According to Uniform Reporting System Guidelines for Table 15 (Living Situation), the number of adults who are homeless/in shelters within all DMH-certified and funded community mental health programs are reported, including specialized programs funded through the federal Projects for Assistance in Transition from Homelessness (PATH) program. Therefore, the percentage of adults who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of adults served by these specialized programs occur. DMH is continuing work ~~in FY 2009~~ to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and ongoing efforts to improve data integrity might result in adjustments to baseline data.

Significance: Specialized outreach and coordination services are needed to identify and address the unique and often complex needs of individuals with mental illness who are homeless.

Action Plan: DMH will continue to provide funding and technical assistance to specialized programs providing outreach and coordination of services for individuals with mental illness who are homeless/potentially homeless, as described in detail under Criterion #4. The Division of Community Services will also continue to participate in interagency groups that address the needs of individuals who are homeless or potentially homeless described under Criterion #4. Activities to address the strategic planning specific to increasing housing options accessible to adults with serious mental illness and described in the State Plan will also continue.

National Outcome Measure: Increased Stability in Housing (URS Table 15): Percent of Adults Reported to be Homeless/in Shelters

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% of adults reported homeless/in shelters	.7%	.8%	.8%	.78%	.8%

Numerator: # adults reported homeless/in shelters by DMH certified/funded providers	402	512	560	474	
Denominator: # adults reported with living situations by DMH certified/funded providers, excluding persons with living situation Not Available	59,625	63,410	59,625	61,028	

Substance Abuse Services

As indicated in the Children’s Services Plan, substance abuse services are also administered by the MS Department of Mental Health, Bureau of Alcohol and Drug Abuse (BADA). Community mental health centers are the primary providers of both community mental health and outpatient substance abuse treatment for adults. Specific objectives addressing the needs of individuals with co-occurring disorders of mental illness and substance abuse are described in the following section under this Criterion on Activities to Reduce Hospitalization/Rehospitalization, since alcohol use has been found to be a major factor in individuals returning to the hospital. 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:

Substance Abuse Services for Adults and Children

Substance Abuse services are administered by the MS Department of Mental Health through the Bureau of Alcohol and Drug Abuse. Community mental health centers, free-standing programs and two state-operated psychiatric hospitals are the primary providers of substance abuse treatment.

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided 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. At the conclusion of FY 2009, there were 6,184 individuals who received these services.

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. These services are provided by 11 community mental health centers, 11 certified free-standing programs and one adolescent program, CARES Center/ the Ark. In FY 2009, there were 414 individuals who received these services.

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 continued to make available funding to 4 certified programs and 1 adolescent program which is the Bradley Sanders Complex, an extension of East MS State Hospital. At the close of FY 2009, there were 1,214 individuals who received these services.

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. These services are provided by 14 community mental health programs, 11 certified free-standing programs and 3 adolescent programs. In FY 2009, there were 3,890 adults and adolescents who received these services.

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. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2009, there were 1,172 adults who received these services.

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. These services are provided by 14 community mental health centers, 21 certified free-standing programs and 1 adolescent program. In FY 2009, there were 4,339 individuals who received these services.

Referral Services: During FY 2009, the Bureau of Alcohol and Drug Abuse updated and distributed the current 2009-2010 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.

During FY 2009, the Office of Constituency Services received and processed approximately 731 calls requesting substance abuse information or assistance in finding treatment and/or other related/support services. Over 24 categories of “problems/needs” were addressed.

Employee Assistance Program: During FY 2009, the Employee Assistance Coordinator updated and distributed 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 continued 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. In FY 2009, vocational services were provided to 128 individuals. Other specialized/support services include providing treatment to individuals who have been diagnosed with a co-occurring disorder of mental illness and substance abuse. All 15 community mental health centers provide co-occurring services through SAPT block grant funds. The Bureau of Alcohol and Drug Abuse continued to provide funding to one of the state-operated psychiatric hospitals to manage a 12 bed group home for co-occurring individuals. In FY 2009, 11,419 individuals with a co-occurring disorder of mental illness and substance abuse were served. 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. At the close of FY 2009, there were 2,191 individuals who were eligible for DUI services and 1,711 inmates at the Mississippi State Penitentiary were eligible for the residential alcohol and drug abuse treatment program at the state penitentiary.

Private Resources

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 292 licensed and/or Certificate of Need (CON) approved beds in FY 2009 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.

Health/Medical and Dental Services/Other Support Services

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. Specific examples of medical/dental services reported as provided/accessed in FY 2009 by individual CMHCs and the Community Services Divisions of the state psychiatric hospitals included: federal Community Health Centers (CHCs), local county Health Department offices, rural health clinics, home health agencies, local county and/or community hospitals, private psychiatric hospitals, local private practitioners (medical, dental and orthodontics), local private practice clinics, free clinics, Voice of Calvary Family Health Center, University of Mississippi Medical Center, local faith-based organizations, the Veteran's Administration, the University of Tennessee School of Dentistry, and the University of Mississippi Medical Center, School of Dentistry.

As mentioned, outpatient health and medical care is also available through federally funded Community Health Centers in the state. There are 21 Community Health Centers with over 157 delivery sites in Mississippi serving approximately 300,000 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, and provide services in a linguistically and culturally appropriate manner. 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 40% of health center adult 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 health care system between \$9.9 and \$17.6 billion a year nationally. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, fulfilling President Obama's Growth Initiative for Community Health Centers. 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 (MSDH) also makes available certain specialized health care programs, such as: Home Care Services for homebound individuals requiring intermittent professional health services while under a physician's care; WIC, the Special Supplemental Nutrition Program for Women, Infants and Children; the Breast and Cervical Cancer Early Detection Program, offering screening to uninsured, underinsured and minority women within specified age ranges for screening; the Domestic Violence/Rape Prevention and Crisis Intervention Program, providing resources through contracts with domestic violence shelters and rape crisis programs, including educational resources; the Family Planning Program; Maternity Services, targeting pregnant women whose income is below 185 of poverty and including special initiatives such as the Perinatal High Risk Management/Infant Services System and the Pregnancy Risk Assessment Monitoring System (PRAMS). 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.

As described previously, in order to receive CMHS funds and other funds administered by the DMH, all 15 mental health centers are required to develop a plan for providing community support services. This plan is developed using an outline of components that includes a requirement for local programs to describe how the program assures that consumers in all geographic areas have access to medical/dental services, how those services are paid for and how those services are provided in a timely manner. When the plans are submitted, they are evaluated by a committee convened by DMH, which includes family members, and corrections must be made until the state is satisfied that the plan adequately addresses requirements in the plan guidance. Annually, each CMHC submits a plan for providing medical, dental and other support services as part of their community support programs plan, which is required as part of the centers' application for CMHS Block Grant funds. In FY 2009 and FY 2010, the Department of Mental Health continued to require that the 15 community mental health centers implement plans for providing medical, dental and other support services. This plan is submitted to the DMH with the

services providers' CMHS Block Grant funding request. The community mental health centers maintain a list of resources to provide medical/dental services, such as general health services, inpatient hospital, preventative, family support immunizations, TB screening, home health services, psychiatric evaluations/medication monitoring and communicable disease evaluation. The Department of Mental Health will continue this requirement in FY 2011.

Social Services

Social Services and Financial Assistance are available through programs administered by the Mississippi Department of Human Services (DHS) 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/support, 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.

Mental Health Case Management Services

Target Population: The following individuals with serious mental illness must be evaluated for the need for case management and provided case management if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated:

- Adults who have a serious mental illness and who receive substantial public assistance (defined as Medicaid); and,
- Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility.

Model of the Case Management System

The philosophy of the Mississippi Department of Mental Health Case Management System is that the provision and coordination of services are an integral part of aiding eligible recipients to gain access to needed medical, social, educational, and other services in order to reach and maintain their highest level of independent functioning. The purpose of Case Management is to assist the consumer in achieving and maintaining the highest possible degree of personal growth, autonomy, and community integration. Responsiveness to persons with severe mental disabilities is maximized through a supportive relationship with a case manager. Inherent in this philosophy are the following principles: Entitlement, Empowerment, Environment, Relationship, and Community.

The DMH requires all CMHCs and community services divisions of the state psychiatric hospitals to offer case management services. It is recognized by the DMH that case management services provide valuable linkage and assistance through the community integration/participation process as well as diversion from hospitalization, particularly for those individuals with high inpatient recidivism rates. In FY 2009, DMH-certified programs reported providing case management services to 15,811 adults with serious mental illness. DMH also provides funding to support for intensive case management programs targeting services to those individuals with the most severe need (i.e., individuals with a co-occurring disorders, individuals referred for civil commitment, those at high risk of rehospitalization, etc.) will help reduce their risk for hospitalization/rehospitalization. The funds support community mental health center staff maintaining supportive contact with consumers and participating in hospital discharge planning to assure a smooth transition from inpatient to community services settings.

In efforts to offer an array of service options to maintain individuals in their community, DMH offers additional case management service options for certification, such as:

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. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider of these services, required by the more complex mental health needs of some individuals with serious mental illness. MIMS may be provided in any appropriate community setting by a staff member who holds at least a Master's degree (in an appropriately related field) and professional license (for example, as a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Master's level Social Worker or a physician) or who is a Department of Mental Health Certified Mental Health Therapist.

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. The service may be provided in the individual's home, school or any other setting that is part of his/her environment. Individual therapeutic support focuses on the reduction/elimination of acute symptoms and is provided during a time when the individual is unable to participate in regular treatment activities, such as partial hospitalization or day treatment. This service must be provided by a staff member with at least a high school or equivalent degree who has completed certification approved by the Department of Mental Health.

Currently DMH is in the process of drafting updated *Rules and Regulations for the Case Management Certification Program*. The DMH Division of Professional Licensure is researching programs offered by other state licensure boards. DMH intends to pilot an online self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program. Providing the case management training program online will provide cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area.

In FY 2009 and FY 2010, case management records continued to be reviewed for meeting the requirement to evaluate adults with serious mental illness who receive substantial public assistance for the need for case management services. As of mid-2010, 100% of the records reviewed reflected that this requirement had been met, that is, there were no citations issued regarding the requirement that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusals placed in writing.

Mental Health Transformation: Involving Consumers Fully in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)

Technical Assistance to Case Managers

Technical assistance for case management services for adults with serious mental illness is available through a designated staff member of the DMH Division of Community Services and through the Case Management Task Force, which meets to discuss changes and improvements to the system.

By March 2010, the Department had conducted/facilitated two Case Management Task Force meetings for FY 2010 (October, 2009 and January, 2010). The following topics were discussed: overview of the DMH Strategic Plan/Mental Health Service Delivery System Transformation Approach; Home and Community Based Waiver Update and availability of services information; and, an overview of wrap-around services. The Case management task force will continue to meet in FY 2011 and address needs as they arise/pertain to case management.

Case Management Outreach

In FY 2010 and FY 2011, the Department of Mental Health will continue to disseminate brochures about case management to the community mental health centers and Community Services Divisions of MS State Hospital and East MS State Hospital for use in public education/out reach activities.

See also objective on Case Management Training and objective on development of the Case Manager Certification Program under Criterion #5 that follows.

Activities to Reduce Hospitalization

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.

Although all community-based services are aimed at preventing hospitalization, when possible, and reducing the rate of rehospitalization, some specific services are key components of community-based systems used as alternatives to inpatient treatment in the event of a crisis, as well as follow-up services once crisis situations have been stabilized. Efforts to improve the emergency response/crisis management systems to improve discharge planning and continuity of care and to provide training on evidence-based practices, such as integrated treatment for co-occurring disorders of mental illness and substance abuse.

Pre-evaluation Screening for Civil Commitment services, a major purpose of which is to reduce the number of inappropriate admissions to the state psychiatric facilities, is available through all 15 CMHCs. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for referral to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals. (See also section on Training of Pre-Evaluation Screening for Civil Commitment under Criterion 5.)

Emergency Response/Crisis Management Services

The *Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Community Services* 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. According to DMH minimum standards, providers must have current written agreements with licensed hospitals on file that: identify the mental health program's responsibility for the consumer's care while he/she is in an inpatient setting; describe the services the hospital will make available to individuals who are referred; and, describe how hospital referral, admission and discharge processes are coordinated with emergency, pre-evaluation screening, and aftercare services. DMH is in the process of revising the *DMH Minimum Standards*, and although it is projected that the revised standards will be finalized by the end of the year, they are still in the draft stage. DMH is planning to revise the emergency response/crisis management service requirement to reflect a seamless system that is readily available and easier for individuals in crisis to access and navigate.

The two major components of existing emergency services available through the 15 CMHCs are a crisis telephone service and when needed, availability of face-to-face contact with a mental health professional. Through the emergency service component, individuals for whom outpatient services are inadequate are often identified. Community mental health centers maintain agreements with local hospitals which, within certain restrictions, are able to treat individuals in lieu of admission to the state hospital. CMHCs might provide professional back-up to hospital staff to further ensure appropriate care. These agreements, however, are in many instances limited. For example, in some regions, the

agreement is for general hospital beds on a priority basis, but the beds are in a general ward and no psychiatrist is on the hospital staff. In these instances, the admission may be made by a local private physician, and the mental health center staff work with the physician on a consulting basis. Recognizing that inpatient care is limited because of a lack of psychiatrists and available psychiatric beds and that inpatient hospitalization can be avoided in many if not most instances if intensive crisis intervention services are readily accessible, the DMH has initiated development of crisis services across the state.

Regional Acute Care/Crisis Stabilization System

To address the need for more immediate access to emergency or crisis services, including acute hospital and crisis stabilization services closer to consumers' home communities and their families, the State Legislature has funded major components to build a regional system. Regionalization of acute care/crisis stabilization services closer to individuals' home communities will facilitate families' participation in consumers' treatment and transition from the hospital and reduce hospitalization and rehospitalization. As these regional service options become available, it is anticipated that the need for continued treatment beds at the two larger existing hospitals will be further reduced. These efforts also address the issue of waiting lists for admission to the larger existing state hospitals at Meridian (East MS State Hospital) and at Whitfield (Mississippi State Hospital). Inpatient services for adults with serious mental illness are currently available statewide through two comprehensive state psychiatric hospitals (Mississippi State Hospital, which historically has served 51 counties, and East Mississippi State Hospital, which has served 31 counties) and on a limited basis through local public or private hospitals. North MS State Hospital and South MS State Hospital, both 50-bed units, provide acute psychiatric services for adults. These two hospitals are designed to provide more immediate access to acute care services, which are anticipated to reduce the need for longer-term stays or continued treatment at the two larger state hospitals in Meridian and Whitfield. Services provided through these two units are coordinated with community mental health center services in their respective regions to facilitate continuity of care before admission and after discharge, thereby further reducing the need for rehospitalization. The goal of both Mississippi State Hospital and East Mississippi State Hospital is to make available quality inpatient services for individuals in need of this level of care, when such services are not available at the local levels.

Provision of more immediate access to crisis services for short-term emergency mental health treatment, for serving persons awaiting commitment proceedings or awaiting placement in a state mental health facility following commitment and for diverting placement in a state mental health facility was a major provision in the 1997 Mental Health Reform Act (SB 2100). Also included in the legislation was a provision to establish regional state offices to provide mental health crisis intervention centers and services to be used on a case-by-case emergency basis. The 1999 State Legislature provided funding for construction of seven community-based crisis centers to be operated as satellites of existing and new facilities operated by the Department of Mental Health. Due to limited funding availability, operational funding was provided over the next five to 10 years.

In FY 2009 the Mississippi Legislature approved the Department of Mental Health Crisis Center Redesign Plan, permitting DMH to transition the operation of one of the seven state-operated crisis intervention centers from Mississippi State Hospital to operation as a crisis stabilization unit by Life Help Community Mental Health Center. This pilot program, located in Grenada, was operated under the Department of Mental Health's community mental health minimum standards for intensive residential programs, rather than under state standards for psychiatric hospitals, which allowed for more progressive programming and resulted in cost reduction. In FY 2010 DMH sought and received

legislative approval to transition the remaining six state-operated units from operation by the state hospitals to operation by regional community mental health centers. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of the remaining six crisis stabilization units (in Batesville, Brookhaven, Cleveland, Corinth, and Laurel); Central Mississippi Residential Center will continue to operate the unit in Newton. The operation of all seven units will be based on the redesign piloted at the center in Grenada, which as mentioned, includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services. The units will serve adults who are admitted on both an involuntary and voluntary basis.

Intensive Case Management

Since FY 2000, the DMH has continued support (including support from the CMHS Block Grant) of the development of comprehensive emergency services systems, of which intensive case management is an important component. In FY 2009 and FY 2010, the DMH continued the support of comprehensive emergency service systems, of which intensive case management is an important component.

Other Intensive Residential Treatment Programs

Additionally, the DMH will continue to provide funding to help support two intensive residential treatment programs for adults with serious mental illness in crisis (in addition to the crisis centers described previously): one will continue operation in Vicksburg, by Region 15 CMHC (Warren-Yazoo Mental Health Services), and one will continue operation in Gulfport by Region 13 CMHC (Gulf Coast Mental Health Center. LifeHelp (Region 6) has integrated the five-bed intensive residential treatment program it operated previously in Greenwood with the crisis stabilization unit in Grenada. Region 13 (based in Gulfport) continues to operate an intensive residential treatment facility in Harrison County. Region 15 (Vicksburg/Warren Counties) opened its intensive residential treatment facility in Vicksburg in July 1998, initially taking voluntary admissions. In October, 1998, they also began serving individuals who had been or were involved in the civil commitment process. The intensive residential treatment facility provides the residential component, while Warren County provides the holding facility component in a separate location. Since opening, the intensive residential treatment facilities in Region 13 and Region 15 have reported a positive impact on diverting individuals from state psychiatric hospital admission.

National Outcome Measure: Evidence-Based Practice – Assertive Community Treatment (URS Developmental Table 16)

Assertive Community Treatment is an evidence-based practice included in the CMHS Core Performance Indicators, the proposed definition of which differs from intensive case management, but which also includes a target population of individuals with more severe and persistent challenges. As mentioned previously, the Person-centered Planning project implemented in four regions targeted individuals at risk for hospitalization or rehospitalization, and is exploring using a more team-oriented approach to transition planning, which is one element of the proposed federal definition of Assertive Community Treatment. In May 2005, staff from the DMH Division of Community Services attended the Annual Assertive Community Treatment (ACT) Conference in Tampa, Florida. Technical assistance on ACT was provided in 2006, through support/collaboration with NAMI-MS; the role that peer specialists might play in provision of ACT services has also been explored. Since that time, DMH Division of Community Services staff has visited with staff of the VA Hospital's ACT team in Jackson. Staff from Region 15's community mental health center have visited the ACT team in Little Rock,

Arkansas (in March 2007), and the DMH sent a team (that includes regional staff that participated in the PCP project) to Oklahoma at the end of FY 2007 to obtain additional, follow-up technical assistance regarding implementation of ACT. Since that time, an ACT Steering Committee has been established to continue work on development of ACT and efforts have continued to seek funding support for ACT teams. DMH continued activities through its Data Infrastructure Grant (DIG) Quality Improvement project to develop the capacity of the central data repository system for data collection and reporting of evidenced based practices, such as assertive community treatment. In 2009, DMH staff and staff representatives from Region 6, Life Help CMHC traveled to Tulsa, Oklahoma to receive training in the PACT model. In April, 2010, the PACT Coordinator from Oklahoma came to Greenwood, MS, to provide onsite technical assistance. Life Help has PACT staff hired and projects that it will begin serving individuals in July 2010.

Goal: Decrease utilization of state inpatient adult psychiatric services

Target: To reduce readmissions of adults to state inpatient psychiatric services by routinely providing community mental health centers with state hospital readmission data by county

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health services

Indicator: Rate of inpatient readmissions within 30 days and within 180 days

Measure: Ratio of civil readmissions to civil discharges at state hospitals within 30 days and within 180 days.

Sources of

Information: Uniform Reporting System (URS) tables, including URS Table 20 (Rate of Civil Readmission to State Inpatient Psychiatric Facilities within 30 days and 180 days)

Special Issues: DMH is continuing work on development of the data system to support collection of information for the core indicators on readmissions to state psychiatric inpatient facilities, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project. Data was reported through the Uniform Reporting System (URS) tables. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other national outcome measures. The current data system does not track individuals across the community mental health and state hospital system; therefore, adults in those two systems, though there is some overlap, are likely to represent two different cohorts, that is, except for receiving a preadmission screening, not all adults served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Chancery Court system. DMH is continuing work to develop capacity to collect data from all funded/certified providers through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now

in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits and to have the capacity to track adults served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: As noted in the State Plan, CMHCs conduct pre-evaluation screening for civil commitment that is considered by courts in determining the need for further examination for and proceeding with civil commitment to the state psychiatric hospitals. Collaborative efforts to increase continuity of care across hospital and community services settings and increased focus on the provision of community-based services, including more timely access to crisis stabilization services are designed to prevent hospitalization and rehospitalization.

Action Plan: The Department of Mental Health will implement initiatives to provide community-based crisis stabilization services, to improve discharge planning and continuity of care for individuals transitioning from inpatient to community-based care, and to provide training on evidence-based, integrated treatment for persons with co-occurring disorders, which are described in the State Plan.

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days and within 180 days: (URS Developmental Tables 20A and 20B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	2.43%	3.5%	4.12%	3.0%	3.4%
Numerator: Number of civil readmissions to any state hospital within 30 days	84	134	175	106	
Denominator: Total number of civil discharges in the year	3457	3845	4244	3552	

Mississippi

2. Decreased Rate of Civil Readmissions at to state hospitals within 180 days	12.79%	17.3%	15.62	14.7%	15.3%
Numerator: Number of civil readmissions to any state hospital within 180 days	442	665	663	524	
Denominator: Total number of civil discharges in the year	3457	3845	4244	3552	

Goal: To reduce involvement of adults with serious mental illness in the criminal justice system.

Target: To continue to collaborate with CMHCs in providing training to law enforcement and to facilitate networking between the mental health system and law enforcement/justice systems to address jail diversion, law enforcement training, and linkage between community mental health services/jails/corrections.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Increase in the percentage of adults with serious mental illness served by the public community mental health system reporting that they had been arrested in one year, but were not rearrested in the next year.

Measure: Percentage of adults with serious mental illness served by the public community mental health system who reported that they had been arrested in Year 1 (T1), but were not rearrested in Year 2 (T1)

Sources of

Information: Uniform Reporting System (URS) data from Table 19A, which are based on results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH), and Division of Community Services grant reports.

Special

Issues: In addition to the data being based on self-report, the low number of total responses to this survey item (105 in 2009) compared to the number of responses to other items on the survey should be considered in interpreting results of this measure. The low response rate to this survey item prior to 2009 may be due to survey instrument design (i.e., the addition of “branching” questions added to the end of the original *MHSIP Consumer Satisfaction* survey instrument to gather information on this NOM), which may be confusing to some respondents, as well as to some individuals’ reluctance to respond to

questions about their involvement in the justice system. Although increasing the survey sample size in 2009 increased the total number of responses, the number responding to this survey remains low in comparison to the total number of individuals responding to other survey items.

Significance: The Department of Mental Health will continue to explore other funding sources to support training of law enforcement personnel to develop appropriate responses to emergency situations involving individuals with mental illness, since law enforcement personnel may often be the first professional staff on the scene of an emergency and can be in a position to divert individuals to mental health services when needed and more appropriate. Increasing networking between the mental health system and law enforcement/justice systems will facilitate the development of more strategies to address issues related to criminal justice involvement, such as jail diversion, law enforcement training, and linkage between community mental health services/jails/corrections.

Action Plan: Because of budget restrictions, DMH will not continue funding support of law enforcement training provided by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers explore other avenues for training for law enforcement and other emergency services personnel and to explore additional opportunities to divert and/or decrease involvement of individuals with mental illness in the criminal justice system, such as described under Criterion 5.

National Outcome Measure (NOM): Decreased Criminal Justice Involvement (URS Table 19A).

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	76%	52%	69%	64%	68%
Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	25	13	75	18	
Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)	33	25	108	28	

Mental Health Transformation Activity: Improving Coordination of Care among Multiple Systems

Mental Health Transformation Activity: Services for Individuals with Co-occurring Disorders (Mental Illness and Substance Abuse) (NFC Goals 4.3 and 5.3)

Implementing a strategic plan to better address the needs of individuals with co-occurring disorders of mental illness and substance abuse is a major task in system transformation efforts. The DMH has pursued initiatives to improve services in this area for many years; most of those efforts were coordinated by what was formerly the Dual Diagnosis Task Force, which was restructured to become the Co-occurring Disorders Coordinating Committee. The group has functioned to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse and sponsored 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 co-occurring disorders.

In April 2005, the DMH received technical assistance from the Center for Excellence on Co-occurring Disorders, sponsored by SAMHSA, which focused on issues pertinent to service planning for adolescents and young adults with co-occurring disorders. DMH's planning efforts were expanded to address the need for a more comprehensive, integrated systems approach across all age groups. As part of that effort, the DMH provided inservice training to state office staff and disseminated SAMHSA's *TIP-42 (Treatment Improvement Protocol)* to substance abuse and mental health community services providers throughout our state. In February 2006, DMH utilized its *Annual State Conference on Co-occurring Mental Health and Substance Related Disorders* to further engage additional stakeholders in planning efforts and to advance knowledge in the field about the evidence for service integration. These focused activities over approximately one year culminated in the development of a draft Strategic Plan for Co-occurring Disorders, developed by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative; this planning session was facilitated once again by the COCE. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded. The Co-occurring Disorders Coordinating Committee was reconvened in FY 2007 to review, refine and address objectives in the plan. Additional technical assistance from COCE was received in 2007 to continue progress on implementation of evidence-based integrated service models. The Co-occurring Disorders Coordinating Committee met in April 2008 and developed subcommittees on workforce development, treatment plan training and screening and assessment. A committee member attended a national training program on TIP 42, and three committee members attended training on the GAIN (standardized assessment instrument). In FY 2009, statewide training sessions were initiated to facilitate implementation of integrated treatment for persons with co-occurring disorders. As of April 2009, staff from Region 12 (Pine Belt Mental Healthcare Resources) was providing consultation, training, and clinical coaching on co-occurring disorders to all 15 community mental health regions. Formal training is being offered on assessment, reporting of diagnosis, and treatment planning for individuals with co-occurring disorders, and including evidence-based practices for providing services to individuals with co-occurring disorders and effective clinical supervision for enhanced clinical outcomes. To date, training has been provided in four regions. As of February 2009, a standardized screening instrument, the GAIN, has been implemented in all regions. The Department of Mental Health received funding from the Center for Mental Health Services 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. By mid-year in FY 2010, three trainers had been identified to provide the training to staff in community mental health regions and from state hospitals

who were not trained in FY 2009. Coaching and technical assistance will also be provided to all 15 regional community mental health centers and to four state hospitals following the training. The training throughout the state is projected to be completed by April of 2011.

Objective: The Co-occurring Disorders Coordinating Committee will continue to meet and make recommendations regarding service delivery and/or training.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Co-occurring Disorders Coordinating Committee Operation

Indicator: Continued operation of the Co-occurring Disorders Coordinating Committee, which will focus on strategies for improving services to adults with co-occurring disorders of serious mental illness and substance abuse.

Measure: The Co-occurring Disorders Coordinating Committee will continue to meet and report to the MS State Mental Health Planning and Advisory Council on its activities, at least annually.

Source(s) of Information: Co-occurring Disorders Coordinating Committee minutes

Special Issues: None

Significance: The DMH allocates funds specifically for the provision of community-based services for individuals with co-occurring disorders. The committee continues to work on identifying and addressing services improvements.

Funding: Federal (CMHS) funds

In FY 2010, funds were provided to continue support for operation of a 12-bed community-based residential facility for individuals with a co-occurring disorder of serious mental illness and substance abuse by the Division of Community Services at Mississippi State Hospital; continued support of these beds is projected for FY 2011.

Objective: Community-based residential treatment services for individuals with co-occurring disorders will continue in one site.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Community residential treatment beds for individuals with co-occurring disorders

Indicator: Continued operation of a residential treatment service for individuals with co-occurring disorders of serious mental illness and substance abuse.

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

PI Data Table A1.16	FY 2007 Actual	FY 2008 Projected	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# Community Residential Dual Diagnosis Beds	12	12	12	12 beds	12 beds

Source(s) of

Information: Program grant

Special

Issues: None

Significance: The need for a specialized integrated treatment program for individuals with both a serious mental illness and a substance abuse problem is supported in the professional literature and a previous study of recidivism at MS State Hospital that indicated that alcohol use is a major factor in individuals returning to the hospital.

Funding: State and Substance Abuse Prevention and Treatment block grant funds

Objective: Community services will be provided for individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Co-occurring disorders - community services availability

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

Measure: The number of individuals with co-occurring disorders to be served (6500)

PI Data Table A1.17	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# Served–Dual Diagnosis	8914	8598	9295	6500	6500

Source(s) of

Information: Adult Services Annual State Plan Survey

Special

Issues: The number of individuals served does not necessarily remain constant or increase across years, but rather depends on needs identified at the local level.

Significance: Individuals with co-occurring disorders of serious mental illness and substance abuse

require specialized services to reduce their risk of hospitalization or rehospitalization. Each CMHC must provide specialized co-occurring disorders services as part of the requirements for receiving SAPT funding for dual diagnosis services.

Funding: SAPT block grant and state funds

National Outcome Measure: Evidence-Based Practice – Integrated Treatment for Co-Occurring Disorders (URS Developmental Table 17)

The DMH will continue to collect/report information in FY 2011 on the number of individuals served by the community mental health centers and Community Services Divisions of MS State Hospital and East MS State Hospital, who have a co-occurring disorder of substance abuse and mental illness, as defined by the state. “The number (and other demographic information) of individuals receiving “integrated treatment for co-occurring disorders” is an evidence-based practice included in the CMHS Core Performance Indicators-and as noted previously, efforts are continuing to monitor and provide technical assistance to facilitate implementation of guidelines for services for persons with co-occurring disorders. In FY 2010, DMH has continued work to develop the capacity to collect and data on the aggregate total of individuals with co-occurring disorders served in specialized programs. Work is also continuing through its Data Infrastructure Quality Improvement Grant (DIG) project to build the capacity of providers to report the detailed demographic information in URS Table 17 on services provided for integrated treatment for co-occurring disorders.

Other Support Services from Public and Private Resources to Assist Individuals to Function Outside of Inpatient Institutions

Public Resources

Mental Health Transformation Activities: Consumer and Family Operated Programs and Involving Consumers and Families in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)

Local Advisory Committees

The MS Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services 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. As part of a comprehensive review of DMH Minimum Standards, in FY 2008, the new Division of Family and Consumer Affairs in the DMH Bureau of Community Services undertook a review of the role of consumers and family members on local advisory councils in Mississippi and in other states and subsequently initiated activities in FY 2009 to improve the effectiveness of the councils. Based on the review, the Division has proposed changes to the Mississippi Department of Mental Health Minimum Standards for Community Mental Services that, if enacted, will provide more specific guidance

regarding the purpose and structure of local advisory councils. The Division has also developed a draft of a toolkit to provide technical assistance to the local advisory councils and plans to develop strategies for dissemination of educational information to the local councils in FY 2010. In FY 2011, the Division will continue to work on encouraging dialogue with and among state advisory councils to assess strengths and needs and supporting local advisory councils based on feedback using the Advisory Council Guide, developed by the Division as a technical assistance tool. The Division will continue to disseminate educational information to the local councils in FY 2011.

Division of Consumer and Family Affairs

Since FY 2007, DMH 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 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.

In April 2008, the Division of Consumer and Family Affairs convened a preliminary workgroup of consumer, family and service provider representatives to begin work to general additional input for further development of the goals and objectives of the new division. By consensus, the preliminary workgroup generated the following suggestions that continue to guide the work of the division:

- Ongoing education of stakeholders, including leadership at the local and state levels, about the importance of consumer and family involvement in services, what that involvement should include;
- Ongoing outreach to build capacity of consumer and family education programs;
- Refinement and education about the role of local advisory councils; and,
- Continued evaluation and refinement of the peer review process.
- Improving coordination of activities designed to increase consumer and family inclusion.

In FY 2009 and in FY 2010, the Division of Consumer and Family Affairs has continued to develop strategies to facilitate a recovery-oriented mental health system. Activities currently being considered include development of an education and information campaign focused on disseminating information about recovery and empowerment and identification of possible avenues at the state and local level for further promoting recovery-oriented systems change, e.g., through existing advisory councils, committees and task forces. Additionally, in FY 2011, the Division will continue to examine strategies that have been successful in other states in promoting recovery and consumer empowerment.

Development of Peer Specialist Services

DMH has received technical assistance on planning for development of peer specialist services in the state (based on Georgia's model). A peer specialist 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, 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 in FY 2009. 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. The Division of Family and Consumer Affairs plans to continue activities to advance the development of peer specialist services in Mississippi, focusing on the provision of education to service providers about the definition and role of peer specialist services in a recovery-oriented system. The Bureau of Community Services will also continue efforts to obtain funding support to provide peer specialist services. Currently, Certified Peer Specialists are working to establish bylaws, goals and a mission statement for Recovery Now, a newly formed consumer coalition. In FY 2010, two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. In FY 2011, the Bureau of Community Services will continue to explore areas to employ Peer Specialists and educate community mental health systems on the role of Peer Specialists in the recovery process. In April 2010, DMH applied for funding through SAMHSA to develop Peer Specialist employment and education opportunities for an increased number of consumers; however, as of early June notification of the grant review had not been received by DMH.

Development of Statewide Consumer Coalition

In FY 2010, the Division of Consumer and Family Affairs and the Division of Community Services continued to facilitate development of an independent statewide consumer coalition. Discussions with interested stakeholders about the potential to develop an independent consumer coalition were held in conjunction with the May 2009 Community Mental Health Conference and facilitated by the National Consumer Empowerment Center. In FY 2010, the Division of Family and Consumer Affairs collaborated with other groups to identify consumers interested in assuming leadership roles in developing a statewide consumer coalition and by seeking guidance on steps to move forward in forming and supporting the coalition, possibly through holding a retreat of identified consumer leaders to discuss forming and supporting a coalition. In FY 2011, the Division of Consumer and Family Affairs will continue to work with the newly formed consumer coalition group, Recovery Now, by providing requested support and technical assistance.

Protection and Advocacy

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. Two recipients of mental health services, who also serve on the Mississippi State Mental Health Planning and Advisory Council, are on the Advisory Council of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) component of Disability Rights Mississippi.

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.

Family Education/Support and Consumer Education Support Programs are designed to address three of the major risk factors found to be associated with rehospitalization of individuals at the largest state psychiatric facility: medication non-adherence, current alcohol use (specifically as it affects individuals with mental illness), and family conflict (including education about serious mental illness and skills needed for effective communication among family members and consumers). The DMH Division of Community Services adopted the Family-to-Family education program, which is conducted by family members, for implementation of the community mental health system's family education component in FY 2000. The Department of Mental Health provides funding to NAMI-MS to make the "Family to Family" education program available to CMHC regions.

The CMHCs are asked to provide support to NAMI-MS in implementing the family education/support program, through such activities as identifying potential participants, providing meeting space if needed, and/or helping to develop a media campaign to advertise the availability of the program. Under current minimum standards, DMH staff monitor local programs for increased documentation of the types of support provided to family education programs. This requirement was added to help increase the availability and uniformity of family education/support programs across the mental health regions in the state. As of June 2010, NAMI-MS had served 44 family members in Family to Family classes. The target for FY 2010 was modified from 70 to 60. Two to three additional training sessions will be scheduled before the end of FY 2010; however, based on the average number of people attending the first three classes in FY 2010 (which was 44), the overall target for FY 2010 was reduced.

For FY 2011, the specific objective for the provision of family psychoeducation was deleted because of a reduction in state funding. DMH will continue to provide federal CMHS Block Grant funds to NAMI-MS, which plans to focus efforts on enhancing the role of affiliates in providing education and support for families and consumers. It is projected that this decentralization will result in a more responsive system. NAMI-MS will also spend time developing an ideal NAMI system model for the state and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education and support.

Provider Education

In FY 2003, NAMI-MS initiated the NAMI Provider Education Program in Mississippi. This is a 30-hour course in mental illness education and consumer/provider/family collaboration skills for line staff at public mental health agencies. The five-member training groups include two consumers, two family members and a mental health professional who is also a family member or consumer. As of April 2009, the NAMI Provider to Provider program had been offered at CMRC; 18 providers were trained during the four-day course. Due to budgetary restraints in FY 2010, NAMI did not conduct any Provider to Provider trainings, and NAMI does not plan to conduct Provider to Provider trainings in FY 2011.

Consumer Education/Support Programs

The Mississippi Leadership Academy (MLA) resulted from a federally funded grant designed to enhance leadership and communication skills of persons with a serious mental illness. Since it was first instituted in Idaho in the early 1990's, over 20 states have become sponsors, with West Virginia having replicated the leadership academy model. The MLA is designed to be offered twice a year; its student body consists of people who are recovering from serious mental illness and who aspire to assume leadership roles in the mental health community, as well as in the community at large. Each class includes approximately 20 graduates. Persons who have participated in Peer-to-Peer training, BRIDGES training or who are interested in increasing their leadership skills will continue to be provided an opportunity to participate in the Academy, as resources are available. As a result of the skills individuals learn in the Peer to Peer classes, NAMI-MS has many consumers who now teach the course throughout the state. Others have represented NAMI Mississippi at the NAMI National Convention, held in various cities across years. Peer to Peer graduates also serve NAMI-MS statewide by presenting their personal stories about living with a mental illness as by serving as support group facilitators.

The Mississippi Leadership Academy (MLA) conducted two training sessions in 2008 and 2009, producing a total of 36 graduates. The Director of the MLA has maintained contact with all graduates through a newsletter and personal correspondence. Many of them report their leadership involvement with mental health training programs throughout the state (NAMI Peer to Peer and In Your Own Voice; State Mental Health Planning and Advisory Council; Consumer Coalition conferences; peer reviews; and, peer advocacy). At least 14 of the graduates have assumed lead roles on the MLA planning team. Five graduates are advisory board members at local CMHCs, with others expected to assume similar roles during this fiscal year. The Director of the MLA continues to strengthen peer reviews, peer counseling and provider education. The 2009 curriculum promoted active consumer advocacy with regard to law enforcement education personnel and crisis intervention. Most students continue to be referred to the MLA by the regional CMHCs and the state NAMI office; however, few referrals have come from private practitioners. The MLA continues to identify liaison with the Veterans Administration to provide outreach to more potential MLA students from that arena. The MLA distributed its first newsletter in December 2008 and the Division of Consumer and Family Affairs is working with the state Information Technology Services (ITS) agency to enhance the website.

A significant step in converting the MLA to a consumer-led program occurred in February 2009, when the MLA Board was established. The Director of MLA is a consultant to this consumer-led board, which plans to assume total responsibility for teaching the curriculum by December 2010. Additionally, CMRC provides illness management and recovery services to individuals they serve, based on SAMHSA Evidence-based Practice (EBP) Toolkit. By mid-year FY 2010, NAMI-MS had trained 24 ; individuals in two Peer to Peer classes. The targeted number for FY 2010 for individuals to be served in

the Peer to Peer Program is expected to decrease because of the loss of a Peer to Peer Coordinator position and reduced funding; however, given the additional individuals projected to receive illness self-management recovery services through CMRC's program, the target remained the same for FY 2010. Three Peer to Peer trainings were scheduled before the end of FY 2010 (July 6-9, 2010, at Beacon Behavioral Health; July 19-22, 2010, at Mississippi State Hospital, Community Services; and, a training session in Meridian, July 26-29, 2010). The Mississippi Leadership Academy has a training session scheduled for December 2010.

In FY 2011, the target for the following objective is being decreased due to a reduction in state funding, which supported the Peer to Peer component of the objective. DMH will continue to provide federal CMHS Block Grant funds to NAMI-MS, which plans to focus efforts on enhancing the role of affiliates in providing education and support for families and consumers. It is projected that this decentralization will result in a more responsive system. Additionally, NAMI-MS will spend time developing an ideal NAMI system model for the state and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education and support.

Goal: To provide family and consumer education and support

Target: To continue to maintain and support Consumer Education/Support programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of Consumer Education Program training.

Indicator: Information about the Mississippi Leadership Academy (MLA) will be made available to individuals with serious mental illness served through the public community mental health system.

Measure: The number of individuals who complete the Mississippi Leadership Academy (MLA)

Source(s) of

Information: Consumer education program records; Grant program reports

Special

Issues: The Consumer Education Programs provided or supported through the CMHC must be NAMI Peer to Peer, the Mississippi Leadership Academy or other program approved by the DMH. The targeted number of individuals to be served through the Illness Management programs (120) was not completely reached in FY 2008 (103 adults received services). This reduced number was due to a change in administrative staff at NAMI-MS (which administers the Peer to Peer program) during that time period, and use of the organization's staff time to initiate the NAMI Connections support program during that year. The number of individuals targeted to participate in the Illness Management programs also reflects a decrease after FY 2008, including reductions in FY 2010 and FY 2011 because of reduced funding, as previously described.

Significance: The Mississippi Leadership Academy is made available to facilitate the development of consumer education and support groups throughout the state. Consumer education programs provide individuals with education about their illness, including coping skills, and facilitate individuals taking a more active role in their recovery. The programs also provide information about how to access and advocate for and about opportunities for the development of self-help groups.

Action Plan: The Mississippi Leadership Academy (MLA) will continue to be made available to individuals served by the 15 CMHCs, and the Division of Consumer and Family Affairs will facilitate the provision of written material for community mental health centers to provide to consumers and/or family members regarding recovery that will address the availability of NAMI Peer to Peer and consumer support programs, as well as the MLA.

National Outcome Measure: Programs for Illness Management and Recovery Skills (URS Developmental Table 17)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Mental Health Transformation Performance Indicator					
Percentage of persons served who received illness management/recovery services*	.26	.20	.14	.08	.03
Numerator: Number Receiving Illness Management/Recovery Services*	127*	103*	73	40	15
Denominator: Number of persons with SMI served (community services)	48,493	52,312	53,910	49,000	49,000

**In accordance with CMHS Reporting Guidelines for Evidence-based Practices, it should be noted that numbers reflect individuals served through programs that involve a specific curriculum; programs will include Peer to Peer, MS Leadership Academy and/or BRIDGES (through FY 2008).*

Other Educational Opportunities

In April 2010, DMH applied for funding through SAMHSA to increase the number of services and supports for consumers and family members such as peer mentoring, peer coaching, support groups, and other educational activities, which would decrease the intensity of services needed for them to remain in their communities; however, as of early June notification of the grant review had not been received by DMH. Increasing an individual’s ability to remain in the community by strengthening community supports and individual resiliency are primary goals of the grant. The Peer Specialists would also be providing Wellness Recovery Action Plans to individuals with serious mental illness. The grant development task force agreed that both the Peer Specialist Program and the WRAP program complimented the goals and objectives of the initiative.

- Objective:** To make available, through local, state or national media, education/training opportunities and materials
- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Availability of consumer educational opportunities
- Indicator:** Continued availability of funding to support educational opportunities for consumers through local, state or national education/training opportunities.
- Measure:** DMH will continue to make available opportunities for consumers to participate in local, state, and/or national trainings and provide educational materials to on self empowerment, recovery, and/or illness management.
- Special Issues:** None
- Significance:** Continuing support of local, state and/or national education/training opportunities. Educational materials distributed will focus on recovery and empowerment, and will be shared with consumers of mental health services, as well as family members, mental health professionals and other interested stakeholders.
- Funding:** CMHS block grant

Other Support Groups

NAMI MS also continues to offer NAMI Connection groups in Jackson (two groups), Meridian, Greenwood, Oxford, Southaven, Vicksburg, Gautier, Gulfport, and Hattiesburg. A NAMI Connection Facilitator training is scheduled to be held in Jackson in August 2010. NAMI Connection Recovery Support Group is an alliance of adults who have in common the experience of living with mental illness. It provides a place to share experiences and use them as learning opportunities for themselves and others. Groups are offered free of charge, meet weekly and are led by trained individuals who are also in recovery.

National Outcome Measures (NOM): Increased Social Supports/ Connectedness (URS Table 9)

- Goal:** To increase social supports/social connectedness of adults with serious mental illness (i.e., positive, supportive relationship with family, friends and community)
- Target:** To continue to support illness self-management and consumer support programs and other activities designed to facilitate individuals taking a more active role in their recovery.
- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system.

Indicator: Percentage of adults with serious mental illness served in the public community mental health system reporting positively regarding social connectedness.

Measure: Percentage of adults with serious mental illness who respond to the survey and who respond positively to items about social support/social connectedness on the MHSIP Satisfaction Survey

Sources of

Information: Results of the MHSIP satisfaction survey from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH) and case management service plans (reviewed by DMH Division of Community Services staff).

Special Issues: DMH has worked with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* in FY 2006 - FY 2009 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

Significance: Improving the social support/connectedness of adults with serious mental illness receiving services is a key indicator in assessing outcomes of services and supports designed to support individuals in taking a more active role in their recovery. Case management facilitates linkage of services/resources for individuals with serious mental illness, ensuring that an adequate service plan is developed and implemented, reviewing progress, and coordinating services.

Action Plan: The Division of Community Services and the Division of Family and Consumer Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care, such as continued support of illness self-management programs (the Mississippi Leadership Academy), continued availability of training on person-centered planning, activities to develop peer specialist services and a statewide consumer coalition, and development of an education campaign that focuses on recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change. These initiatives support an individual identifying their strengths and taking a more active role in their recovery, as well as in providing opportunities to support other consumers in recovery. Case managers will also continue to provide linkage and referrals to community resources (such as illness self-management and support services).

National Outcome Measures (NOM): Increased Social Supports/ Connectedness (URS Table 9)

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance					

Indicator					
% age of Families of adult consumers reporting positively regarding social connectedness	75%	71%	76%	73%	74%
Numerator: Number of adult consumers reporting positively about social connectedness	500	447	1112	445	
Denominator: Total number of adult consumer responses regarding social connectedness	667	629	1470	607	

National Outcome Measure (NOM): Improved Level of Functioning (URS Table 9)

Goal: To increase satisfaction of adults with serious mental illness regarding their functioning

Target: Increase or maintain the percentage of adults with serious mental illness who respond positively about their functioning

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Percentage of adults with serious mental illness reporting positively regarding functioning.

Measure: Percentage of adults with serious mental illness who respond to the survey and who respond positively to items about their functioning on the *MHSIP Consumer Satisfaction Survey*.

Sources of

Information: Results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH)

Special Issues: Implementing many of the same initiatives aimed at improving outcomes and described in the previous National Outcome Measure on outcomes is projected to also impact individuals' perception of their functioning (described in this National Outcome Measure). These initiatives include activities to provide consumer education and support, to facilitate individuals taking a more active role in their recovery and to disseminate evidence based practices.

Since FY 2007, DMH has continued to work with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in

the URS Table 9 submission and are reflected in the performance indicator table. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

Significance: Improving the functioning of adults with serious mental illness receiving services (from their perspective) is a key indicator in assessing progress on other goals designed to improve the quality of services and support recovery-oriented systems change.

Action Plan: The Division of Community Services and the Division of Consumer and Family Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care that 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, and the initiative to provide training on providing evidence-based, integrated treatment for persons with co-occurring disorders.

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
% age of Families of adult consumers reporting positively regarding functioning	69%	72%	72%	71%	72%
Numerator: Number of families of adult consumers reporting positively about functioning	467	456	1053	433	
Denominator: Total number of adult consumer responses regarding functioning	673	629	1458	609	

Private Resources

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. The Department of Health, which collects data on private psychiatric facilities it licenses, reported 535 licensed/inpatient beds, with an additional seven beds held in abeyance and 34 CON approved beds by MSDH in FY 2009 for psychiatric services for adults (excluding DMH hospitals and including 21 beds at University Medical Center). The MS Department of Mental Health does not collect data on inpatient hospitals; that information is maintained by the MS State Department of Health, which licenses those facilities in the private sector.

Name of Performance Indicator: Evidence Based – Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	29%	29%	29%	29%	14%
Numerator	2	2	2	2	1
Denominator	7	7	7	7	7

- Goal:** To promote use of evidence-based practices in the community mental health services system for adults.
- Target:** To continue activities to facilitate dissemination of evidence-based practices in services for adults with serious mental illness
- Population:** Adults with serious mental illness
- Criterion:** Comprehensive Community-Based Mental Health Service System
- Indicator:** Information will be provided to maintain use of one evidence-based practice for adult services (illness self management) and to facilitate steps in dissemination of additional evidence-based practices (integrated treatment for individuals with co-occurring disorders of mental health and substance abuse and assertive community treatment (ACT))
- Measure:** The number of evidence-based practices for adults with serious mental illness implemented.
- Sources of Information:** Consumer education program (Mississippi Leadership Academy) records (grant program records)
- Special Issues:** As noted previously, the objective to provide family psychoeducation services through NAMI's Family to Family program was deleted for FY 2011 because of reductions in funding. The pace (and scope) of progress to facilitate dissemination of additional evidence-based practices (integrated treatment for individuals with co-occurring disorders and assertive community treatment) are likely to be impacted by the availability of funding resources.
- Significance:** The provision of evidence-based practices for adults with serious mental illness is key to improving service outcomes and supporting a recovery-oriented approach to treatment and overall system transformation.
- Action Plan:** Objectives to maintain EBPs (illness self management) and activities to promote the dissemination of additional evidence-based practices (integrated treatment for co-occurring disorders and ACT) described in other sections in the State Plan will be implemented.

Criterion 2: Mental Health System Data and Epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1) (Criterion 1, previous section.)

Prevalence Estimates

Prior to the needs assessment process begun as part of the initial development of the state plan under P.L. 99-660, the state initially applied national prevalence estimates to state population data to derive a broad estimate of need for mental health services among adults. Since current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating incidence and prevalence of serious mental illness among adults, in this year's (FY 2011) State Plan, Mississippi will utilize 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. Estimates in the FY 2011 State Plan are updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state, 2009, prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). As noted in the estimation methodology in the Federal Register, at this time, "...technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that in the future, "incidence and prevalence data will be collected."

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. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in 1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the "12-month prevalence is estimated nationally to be 5.4 percent..." As stated in the publication, these estimates are based on noninstitutionalized individuals living in the community. Also, as pointed out in the discussion of the federal estimation methodology, "only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time." The definition of serious mental illness among adults in Mississippi, described under this criterion, falls within the federal definition.

Goal: To include in the State Plan a current estimate of the incidence and prevalence among adults with serious mental illness, in accordance with federal methodology.

Objective: To include in the State Plan an estimate of the prevalence of serious mental illness among adults in the state.

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Prevalence estimate methodology

Indicator: Utilization of revised estimated prevalence ranges of serious mental illness among adults in the FY 2011 State Plan (as described above), based on the final estimation methodology for adults with serious mental illness published in the June 24, 1999 Federal Register.

Measure: Inclusion of prevalence estimates derived using federal methodology in the FY 2011 Plan.

Source of

Information: Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.

Special

Issues: There are limitations to the interpretation of this prevalence estimate, explained above.

Significance: Estimates of prevalence are frequently requested and used as one benchmark of overall need and to evaluate the degree of availability and use of mental health services.

Funding: Federal and state funds

State-level Estimates of Prevalence of Depression and Anxiety

As described under Criterion #5 under Information Management, in FY 2005 the DMH began collaborating with the Mississippi Department of Health (DOH), which applied to and received funding from the Centers for Disease Control and Prevention (CDC) to collect state-specific information about depression and anxiety in calendar year 2006 as an additional optional data collection module, administered as part of an existing population behavioral health status survey, the Behavioral Risk Surveillance System (BRFSS). This population-based telephone survey (of adults) is administered annually by the DOH and collects data in response to core health-related questions, which is reported to the federal Centers for Disease Control (CDC). In FY 2006, the DMH also collaborated with the DOH in development of an additional funding proposal submitted by DOH to the CDC for implementation of another optional module to collect state-specific data on serious psychological distress and stigma in calendar year 2007. Data was completed during calendar year 2007. DMH applied for and received an Administrative Supplement to its Mental Health Data Infrastructure Grant (DIG) to support this collaborative work with the DOH to collect and analyze state-specific mental health prevalence estimates for adults in 2006 and 2007 and in 2010. Additionally, the Mississippi Department of Health included the depression and anxiety module in the BRFSS in 2008 and in 2010.

Quantitative Targets: Number of Individuals to be Served

Goal: To make available a statewide, comprehensive system of services and supports for adults with mental illness

Target: To maintain or increase access to community-based mental health services and supports, as well as to state inpatient psychiatric services, if needed, by adults with mental illness

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

Indicator: Total number of adults with mental illness served through the public community mental health system and the state psychiatric hospitals.

Sources of

Information: Aggregate data in Uniform Reporting System (URS) Tables 2A and 2B, submitted by DMH funded and certified providers of community mental health services to adults and by DMH-funded state psychiatric hospitals.

Special Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. Data was collected and reported through the Uniform Reporting System (URS) tables on persons served in the public mental health system age 18 and older by gender, race/ethnicity and includes data from the four state-operated inpatient psychiatric units for adults, as well as the DMH-funded community mental health service system. At this point, combined data (above) from the inpatient units and the community mental health programs may include duplicated counts. Also, two of the state-operated psychiatric hospitals provide only acute (short-term) psychiatric inpatient services; the other two hospitals provide both acute and continued (long-term) services. DMH has continued work on developing the capacity for collection of data for the National Outcome Measure on access to services, including addressing duplication of data across community and hospital systems and other issues, with support from the CMHS Data Infrastructure Grant (DIG). DMH has continued work in on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project.–As this system continues to be implemented, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed. DMH continued work to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 2. As noted under the objective *on Information Management Systems Development* under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions and to address other data integrity issues also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports

generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: This objective provides an estimate of the service capacity of the public mental health system to provide services to adults with mental illness in FY 2011.

Action Plan: The Department of Mental Health will continue to make available funding and technical assistance to certified community mental health service providers and the state psychiatric hospitals for the provision of statewide services adults with mental illness.

National Outcome Measure: Increased Access to Services (Persons served in the public mental health system, ages 18+ by gender, race/ethnicity) (Basic Tables 2A and 2B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator					
Total persons 18+ years served in public mental health system*	61,570	65,145	67,611	62,000	64,775

*Includes adults with any mental illness (not just SMI) served in state inpatient units and public community mental health programs funded by DMH. Totals to date do not represent unduplicated counts across programs reporting; therefore, baseline data are projected as targets, as duplication in reporting is addressed in ongoing data infrastructure development activities; downward adjustments are anticipated.

Target or Priority Population to be Served Under the State Plan

Definitions - Adults with Serious Mental Illness

Note: As described in the Children’s Services Plans and in the current Mississippi Division of Medicaid Community Mental Health Manual since FY 2003, the upper age limit in the definition for children with serious emotional disturbances has been extended to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. This is a difference from the federal definition for children, which defines children as being up to 18 years. The change in Mississippi’s definition has been made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. (Totals from data in the NOM (URS Tables 2A and 2B) that follow, however, reflect only adults 18 years and above served; detailed data from URS Tables 2A and 2B indicate that 3836 youth/young adults in the 18-20 year age range were served in FY 2008). 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. It should be noted in the following objective that the number of adults targeted to be served includes only adults with serious mental illness served through the public community mental health system, which is a subset of the number of adults with any mental illness accessing services in the public community mental health and inpatient system,

reported in the previous NOM (URS Tables 2A and 2B).

Goal: To make available a community-based, statewide, comprehensive system of services and supports for adults with serious mental illness.

Objective: To provide community mental health services to adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Total number of adults with serious mental illness served

Indicator: The number of adults with serious mental illness who receive any community mental health services through the public system (15 CMHCs and Community Services Divisions of the state psychiatric hospitals.)

Measure: The number of adults with serious mental illness who receive services through the public community mental health system (minimum 49,000)

PI Data Table A2.1	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# Adults with SMI Served	48,493	52,312	53,910	49,000	49,000

Special

Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

Significance: This objective provides an estimate of the service capacity of the public community mental health system to provide services to adults with serious mental illness in FY 2010, the priority population served by the DMH Division of Community Mental Health Services and the population eligible for services funded by the CMHS Block Grant.

Funding: CMHS Block Grant, Medicaid, other federal grant funds as available, state and local funds, other third party funds and client fees.

Data Management: The management of adult and children’s community mental health services data, including work to establish unduplicated counts, is addressed in the data management objective described in this Plan under Criterion #5 that follows.

Mental Health Transformation Activity: Anti-Stigma Campaign (NFC Goal 1.1)

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. The Mississippi Department of Mental Health (DMH) and the Think Again Network will continue 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 through its Think Again campaign.

In October 2009, DMH and the statewide Think Again Network launched a campaign specific to Mississippi entitled, "Think Again." The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children's Services and Adult Services State Plans. DMH established the Think Again Network 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.

DMH is conducting a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi's Think Again efforts have joined forces with DMH's Youth Suicide Prevention Campaign, "Shatter the Silence." DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, presentations and the distribution of flyers and brochures on campus.

In October 2009, DMH and the Think Again Network launched the Think Again campaign which is an anti-stigma and mental health awareness campaign targeting young adults. Educational materials were developed for the campaign which focuses on the truths about mental illness, how to seek help, and how to fight stigma. Since Oct. 1, 2009, more than 18,000 Think Again brochures and 500 posters have been distributed. DMH worked with the Department of Education to send packets to more than 800 6th – 12th grade public school nurses and counselors with a letter announcing the campaign and offering brochures, posters and presentations free of charge. As a result of the mail out, DMH received requests for more than 8,000 brochures. DMH has conducted more than 70 presentations statewide. DMH continues to combine the anti-stigma campaign efforts with the youth suicide prevention efforts. DMH conducted training in February to prepare 15 individuals to present the Think Again/Shatter the Silence presentations in their community and local schools. In October, several activities were conducted in conjunction with the campaign launch including Weems Community Mental Health Center's Mind Matters event, Mississippi State Hospital's Games Your Children Play Part II event, and Central Mississippi Residential Center's Mental Health Awareness Event. Touglao College sent a text message to all their students announcing the campaign and offering mental health help. More than 20 television and radio interviews have been conducted and more than 70 newspaper articles have been printed reaching more than 900,000 Mississippians.

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

Objective: 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 ~~A~~ anti-stigma campaign.

Population: Adults and children

Brief Name: Anti-Stigma Campaign – “Think Again”

Indicator: To reach 200,000 individuals during FY 2011

Measure: 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. DMH will also track the number of live interviews and presentations.

MH Transformation PI Data Table	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2007 Plan	1.3 million reached	200,000	200,000	200,000

Source(s) of

Information: Media and educational presentation tracking data maintained by DMH Director of Public Information.

Special

Issues: Activities to plan and kick-off the first year of the three-year anti-stigma campaign began in FY 2007, therefore, the different themes will overlap the fiscal year(s) addressed in the State Plan. The anti-stigma campaign has partnered with DMH’s youth suicide prevention campaign for presentations and information distributed to young adults.

Significance: Although youth and young adults, 18-25 years of age, are almost double that of the general population, young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on. The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness.

Funding: Federal, State and/or local funds

Additional services available through the public community mental health system to prevent or decrease hospitalization and rehospitalization include mental health outreach services, case management, crisis telephone services, transitional residential programs, discharge planning and consultation/education services.

Criterion 3: Children Services (only in Children’s Plan)

Criterion 4: Targeted Services to Rural and Homeless Populations-

- Describes States' outreach to and services for individuals who are homeless
- Describes how community-based services will be provided to individuals residing in rural areas

Mental Health Transformation Activities: Services for Elderly Persons (NRC Goal 4.4)

According to the 2000 U. S. Census, approximately 16% of Mississippians are age 60 and older. Elderly persons (over 60 years old) with serious mental illness comprised approximately 6.9% of adults with serious mental illness, age 65 and above were served through the public community mental health system in FY 2009.

Local Plans for Services for Elderly Persons

Historically, a task force was established in 1989 to examine more closely the specialized needs of elderly persons with serious mental illness and to develop strategies to meet those needs for integration in the State Plan. Since that time, all 15 CMHCs have developed a local plan for services to elderly persons with serious mental illness utilizing a guide that emphasizes outreach, interagency coordination of services and case management. The Elderly Services Task Force was reconvened in November 2007 and met again in February 2009 and in March, 2010. By March, 2010, all 15 CMHCs had submitted local plans for elderly services.

- Goal:** To provide community mental health and other support services for elderly persons with serious mental illness.
- Objective:** To make available a coordinated local plan for providing services to elderly persons with serious mental illness in all CMHC regions.
- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system
- Brief Name:** Availability of local plans for elderly services
- Indicator:** Availability of a local plan for providing services to elderly persons with serious mental illness.
- Measure:** The number of CMHCs that submit a local plan for providing services to elderly persons with serious mental illness. (Minimum: 15)

PI Data Table A1.6	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 Target
Local Plans for Elderly Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

*Target modified due to Hurricane Katrina.

Source(s) of

Information: Community Mental Health Center Local Plans for Elderly Services

Special

Issues: None

Significance: The plans will indicate the services that are provided for elderly persons with mental illness in each region.

Funding: Medicaid, state, local, Area Agencies on Aging

Elderly Psychosocial Rehabilitation Programs

Elderly psychosocial rehabilitation is defined as a program of structured activities designed to support and enhance the ability of elderly consumers to function at the highest possible level of independence in the most integrated setting appropriate to their needs aim to improve skills that promote independence in daily life. Standards for the program emphasize community outreach, specialized staff training and medical monitoring of individuals served in the program. One of the program goals, in addition to providing a daily therapeutic environment that is age-appropriate, is to establish an outreach program that focuses on locating elderly persons in the community through various means of public awareness, community meetings, and working with other local organizations.

Since FY 2001, the DMH has continued to identify and assist regions in starting elderly psychosocial rehabilitation programs where appropriate populations could benefit from these services. An elderly service program application must be completed by the provider and approved by DMH prior to the program's certification visit. This ensures that prior to an elderly program certification visit, certain elements of the program have already been reviewed and the region has a clear understanding of DMH expectations regarding services. As of April 2009, there were 58 elderly psychosocial rehabilitation programs, including 27 elderly psychosocial programs in CMHCs and 31 elderly psychosocial programs in nursing homes in CMHC Regions 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14 and 15. Given the expansion of elderly psychosocial rehabilitation programs to date, focus of DMH Division of Community Services activities continue to be on monitoring local programs and providing technical assistance, both to existing and new providers of the service. Part of the FY 2004 CMHS Block Grant increase used to support technical assistance for elderly psychosocial rehabilitation programs made available through model sites operated by Region 15 Warren-Yazoo Mental Health Services and Region 12 Pinebelt Mental Healthcare Resources continued to be available in FY 2008. Staff employed in the programs are encouraged to attend the training prior to employment. The training is also offered to staff from other elderly psychosocial programs that receive repeat deficiencies during annual site visits. Objectives of the training are to:

- Identify staff roles and responsibilities for the development, growth, and enhancement of the program
- Understand the importance and effectiveness of planning
- Establish a schedule of daily activities to meet the social, emotional, and physical needs of the participants
- Establish a list of helpful resources for securing both individual and group activities appropriate for the program participants
- Understand and identify transportation safety requirements and certifications
- Establish an environment to meet the physical, social, and emotional needs of the participants

- Identify and document effective ways to provide information about the program and outreach to the community
- Understand the delivery and effectiveness of other services, including individual, group, family therapy, case management services, and nursing services
- Understand and document all necessary data as it relates to program

As of March, 2010, the training site in Vicksburg (Region 15) had provided training to three individuals, the site in Hattiesburg (Region 12) had trained three individuals, and the elderly psychosocial nursing home training site had provided training to four individuals.

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

Objective: To increase the availability of skills training for staff of elderly psychosocial rehabilitation programs.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Specialized training for elderly services staff

Indicator: Provision of training for additional staff in elderly psychosocial rehabilitation programs.

Measure: The number of community mental health services staff who complete training for elderly psychosocial rehabilitation programs.

Mental Health Transformation PI Data Table C5.3	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2011 (Target)
Availability of training for staff in elderly psychosocial rehabilitation programs	Part of another objective in FY 2007; Region 15 CMHC training site provided training to 37 participants	Training for 33 staff from elderly psychosocial rehabilitation programs was provided	Training provided for 20 staff from elderly psychosocial rehabilitation programs	Training for 10 staff from elderly psychosocial rehabilitation programs	Training for 10 staff from elderly psychosocial rehabilitation programs

Source(s) of

Information: Division of Community Services monthly grant report forms

Special

Issues: The number of staff targeted for training was reduced due to travel budget constraints.

Significance: Expansion of training in this area will address needs to enhance skills of community mental health services staff in providing services to elderly persons with serious mental illness

Funding: CMHS Block Grant, local funds

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.

Specialized Outreach and Service Programs for Individuals with Serious Mental Illness who are Homeless/Potentially Homeless

The Department of Mental Health plans to continue support for 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 the federal funds (Projects for Assistance in Transition from Homelessness or PATH) would have the greatest impact. The programs that are funded are located in Jackson (MS State Hospital Homeless Program) in Meridian (East MS State Hospital, Community Services Division), and on the Gulf Coast (Mental Health Association of MS, Gulf Coast Women’s Center and Singing Rivers Services). As of March, 2010, the PATH-funded programs had served the following: Gulf Coast Women’s Center –37; MSH Community Services –78; Region 14 Singing River Services –35; Mental Health Association of Mississippi –115;and, EMSH Community Services –72 for a total at mid-year of 343 people served thus far in FY 2010. These providers may change after May, 2010, as the Department of Mental Health’s Request for Proposals (RFP) for PATH is a competitive process this year. RFPs have been sent to all counties through Mississippi’s three Continua of Care – Opens Doors, Partners to End Homelessness and Mississippi United to End Homelessness. The Department of Mental Health also 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.

- Goal:** To provide coordinated services for homeless persons with mental illness.
- Objective:** Continued provision of services for homeless individuals with mental illness and individuals at-risk of homelessness in targeted areas of the state.
- Population:** Adults with Serious Mental Illness who are homeless/potentially homeless
- Criterion:** Targeted services to rural and homeless populations
- Brief Name:** Services individuals with serious mental illness who are homeless
- Indicator:** Specialized services will continue to be available for homeless individuals with mental illness in targeted areas of the state
- Measure:** The number of persons with serious mental illness served through specialized programs for homeless persons (833)

PI Data Table A4.1	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# Served– Specialized Homeless	931	913	654	900	833

Source(s) of

Information: Adult Services State Plan Survey; PATH Grant Annual Report.

Special

Issues: The number served in previous years included those enrolled in the PATH program and others who had contact and were provided some assistance, but not enrolled. The results of a needs assessment changed the areas of the state targeted to continue to receive PATH funding for provision of services to individuals with serious mental illness who are homeless. Data will continue to be collected since this reconfiguration of programs.

Significance: Specialized outreach and services are needed to identify and address the needs of individuals who are homeless and who also have a serious mental illness, which are often unique and complex.

Funding: PATH (if available), local, and state funds

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, which was created in the spring of 2002 out of the need expressed by Jackson shelter operators for assistance in serving persons with mental illness who are homeless who use their facilities. Spearheaded by the MS State Hospital Community Services Stubbs Homeless Program, the alliance is comprised of about 20 local agencies, shelters, secondary treatment programs, hospitals and mental health programs. The group's mission is "to provide avenues for information sharing, education and support among emergency/transitional shelter staff and mental health services staff, with the goal of facilitating timely and reliable linkage of mental health services for individuals with mental illness who are homeless."

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. The Partners to End Homelessness (Partners), a group of local service providers, is a permanent partnership to coordinate services to homeless persons in the City of Jackson and Hinds County. Partners is a community-wide effort involving nonprofit agencies, local government and other providers of services to homeless persons, housing providers, neighborhood groups and homeless or formerly homeless persons. The principal organizations involved include: Stewpot Community Services, the Salvation Army, the Veterans Administration Homeless Services, Catholic Charities, Inc., the Hinds County Human Resource Agency, Jackson-Hinds Comprehensive Health Center Homeless Clinic, the City of Jackson, the Mental Health Association of the Capital Area, Inc., the MS Department of Mental Health/PATH, the Hinds County Board of Supervisors, the Recovery Lodge, MS State Hospital Community Homeless Services, the Good Samaritan Center, Southern Christian Services/PALS, the Jackson Housing Authority, the

Mississippi

Mississippi Regional Housing Authority No. VI, Voice of Calvary Ministries, Habitat for Humanity, Daybreak Shelter, Gateway Rescue Mission, New Hope Foundation, and Victory Community Resource, Inc. The Continuum of Care, which is completed by the Partners to End Homelessness, serves to formalize the working relationships, expand and enhance the type and quantity of services that are available for homeless persons in the local community, and provide a strategy for setting and reaching goals to help homeless persons become self-sufficient. A key aspect of the system is the completion of an annual survey among providers of services for homeless persons to help identify gaps in services.

Membership of the Mississippians United to End Homelessness Coalition is statewide and represent the Multi-County Community Action Agency in Meridian, Recovery House in Columbus, Bolivar County Community Action Program, Inc. in Cleveland, Catholic Charities (Guardian Shelter) in Natchez, the City of Natchez, the U.S. Department of HUD in Jackson, the Institute for Disability Studies at the University of Southern Mississippi in Hattiesburg and in Jackson. The goals of this group are to: serve as the lead entity in ongoing efforts to develop and implement a regional Continuum of Care plan; sponsor technical assistance workshops around the state for prospective organizations interested in applying for federal housing funds; and, facilitate and organize advocacy efforts on behalf of homeless persons, such as testimony before elected officials.

By March, 2010, DMH had participated in a Federal on-site review of the PATH program. In FY 2010, a DMH staff member also 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 members also attended monthly MissionLINKS meetings and bi-monthly Partners to End Homelessness committee meetings. MissionLINKS and Partners to End Homelessness are both groups comprised of area organizations dedicated to serving persons experiencing homelessness. The State PATH Contact, within DMH, had also conducted site visits of the five PATH programs.

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

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Gatekeeper workgroup operation and activities

Indicator: Continued participation by a DMH staff member on interagency workgroups that identify and/or address the needs of individuals who are homeless.

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

Source(s) of Information: Minutes of workgroup meetings and/or Division Activity Reports

Special Issues: The DMH staff member who works with this committee and/or other appropriate DMH staff members will also participate in additional interagency workgroups addressing homelessness (such as the Partners to End Homelessness, the MS United to End Homelessness Coalition, and MISSIONLinks), as requested. The Division of Planning

will collaborate with and integrate the activities of these workgroups, which has been ongoing, as needed into a broader strategic plan for housing for persons with mental illness.

Significance: By the DMH Division of Community Services or other appropriate DMH staff participating on various interagency workgroups concerned with the needs of homeless persons, including individuals with serious mental illness, opportunities for maximizing human and fiscal resources to address those needs in a coordinated manner are enhanced. DMH staff participation in groups concerned with the needs of all homeless individuals further ensures that any specialized needs or concerns of homeless persons who also have a serious mental illness are included in the work of those groups.

Funding: State, and federal funds

Definition of areas of the state considered "rural":

In its continued efforts to assess needs and plan strategies to meet those needs in rural areas, the Department of Mental Health will use the new definition of “rural,” based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:

“Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)” are classified as “rural.” More specifically, the Census Bureau “delineates UA and UC boundaries to encompass densely settled territory, which consists of:

1. Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
2. Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are “split” between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural.”

Outreach and Provision of Services to Individuals Residing in Rural Areas

The problems of service availability and access associated with providing services in rural areas, such as transportation, are addressed through both structural and programmatic characteristics of the public community mental health system, including:

Regionalization of Community Mental Health Services

Mississippi is divided into 15 multi-county regions for the planning and implementation of community mental health services. Community mental health services are provided through comprehensive centers located in each region.

County Mental Health Services/Offices

The comprehensive regional community mental health centers maintain services in each county of the

service region to improve accessibility of community mental health services.

Mobile Medication Evaluation/Monitoring

Appropriate staff from comprehensive community mental health centers make trips throughout the regions for monthly medication checks for center clients receiving medication through the community mental health center. The 15 CMHCs will continue to make available medication evaluation/monitoring services to individuals with serious mental illness living in all counties, including those that are rural.

Transportation

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 Department of Mental Health. In FY, 2009, 15 CMHCs, the Community Services Divisions of EMSH and MSH, and CMRC reported utilizing center operated van/other vehicles; 10 CMHCs reported making transportation affiliations agreements with other agencies; and 11 CMHCs, the Community Services Divisions of EMSH and MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

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

Objective: Transportation services will be made available to facilitate access to mental health services for individuals who lack transportation and live in areas removed from delivery sites.

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Availability of local transportation plans

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

Measure: The number of CMHCs that have available local plans that address transportation services (minimum, 15)

PI Data Table A4.2	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Local Plans Addressing Transportation	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Source(s) of Information: Community support services plan reviews.

Special Issues: None

Significance: Transportation assistance is needed by some consumers to have access to the services that are available in their communities and/or region.

Funding: Local, Section 18 contracts, Section 16b2 purchasing, SSBG, state, and local funds

Mississippi Statewide Coordinated Transportation System Project

In FY 2008, the DMH Division of Community Services continued implementation of a Rebalancing Initiative, the Mississippi Statewide Coordinated Transportation System project, which was funded through a Real Choice Systems Change Grant that ended on September 30, 2008. The purpose of this planning grant was to develop a design and implementation plan for a statewide coordinated transportation system that will allow Mississippians with disabilities to access community-based long-term supports anywhere in the State, thereby enabling them to 1) live in the most integrated community setting appropriate to their individual support requirements and preferences; 2) exercise meaningful choices about their environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and 3) obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

The no-cost extension period of the project included the project's final year from October 1, 2007 through September 30, 2008. The major activities of the project during this period included the following: (1) The Mississippi Transportation Coalition, which includes approximately 40 member organizations and serves as the advisory group to the Mississippi Coordinated Transportation System project, continued to meet monthly to develop a plan for coordinated transportation services in Mississippi. (2) The Coast Transportation Coalition, a sub-group of the Mississippi Transportation Coalition, continued to meet. This group was organized to ensure that the plan for coordinated transportation services developed by the Mississippi Transportation Coalition addresses the service needs of citizens in Hancock County, which was especially hard hit by the effects of Hurricane Katrina. (3) The Coalition developed a general description of a coordinated transportation system for the State, providing an overview of how the system should be organized and the roles of the primary stakeholders. (4) Components of the coordinated transportation system were implemented and tested through the Solutions for Individualized Transportation (SIT) project for their effectiveness and recommended inclusion in the final plan for the coordinated transportation system. This project is funded by the Mississippi Council on Developmental Disabilities and managed by The Arc of Mississippi. (5) Staff of the Mississippi Coordinated Transportation System project wrote a grant, which was funded by the Mississippi Council on Developmental Disabilities, to develop specifications and identify possible funding sources for a transportation call center, to be developed in Vicksburg. 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.

The Telepsychiatry Project (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), and expanded to some satellite sites in FY 2010. They have expanded this service across other counties in the Delta and expect to have all community mental health

centers in that region connected by the fall of 2010. The project also is designed to provide training to front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing).

Minimum services typically available through satellite offices/services include outpatient, medication evaluation, pre-evaluation screening, and/or case management.

Satellite offices or services of regional CMHCs located in 95% of the counties in MS that are designated as rural will continue to make available mental health services to rural areas of the state.

Criterion 5: Management Systems-

- **Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan.**
- **Provides for training of providers of emergency health services regarding mental health**
- **Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved 2011**

Financial Resources	Available in FY 2010	Projected for FY 2011
Federal Grants (CMHS, SSBG, SAPT, PATH)	5,172,445	5,172,445
State Funds (grants, Medicaid match)	15,806,402	15,806,402
Healthcare funds (grants, Medicaid match)	2,871,990	2,871,990
Trf. from CMHCs for Medicaid match	4,665,100	4,665,100
Special Funds (EMSH/MSH)	5,923,525	5,923,525
Crisis Center funding (total funding)	18,003,291	18,003,291
Local Taxes*	5,045,379	5,045,379
Local Fees	2,750,000	2,750,000
Federal Medicaid Reimbursements*	74,596,500	74,596,500
Total	134,834,632	134,834,632

*Based on estimated use of funds for adult services of 55% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

Efforts to Increase Funding

Mississippi's budget process is such that funds the Department of Mental Health requested in the 2010 legislative session, which began in January of 2010, would be made available for the fiscal year that begins July 1, 2010, and ends June 30, 2011. In its initial budget request for FYE 6/30/2011, the Department of Mental Health requested an increase of \$56,030,731 (an increase of about 25½%). This requested increase was for all services provided through the Department (mental health services for adults and children, services to persons with substance abuse diagnoses, services to persons with intellectual and developmental disabilities, and services to persons with Alzheimer's disease and other dementia; inpatient and outpatient services in all areas). Included in that requested increase, which totaled \$45 million, were (1) funding to replace loss of enhanced Federal share of Medicaid under the American Recovery and Reinvestment Act (about \$13 million); (2) additional funding to fully fund Medicaid match for the CMHC program (about \$30 million) and (3) funding to replace a reduction in grant funding (about \$2 million). None of the requested increase was awarded. Additionally, the original general fund appropriation for FYE 6/30/10 (approximately \$220,500,000) was cut to about \$200,000,000 during the fiscal year due to declining tax revenues. This cut was taken entirely from residential and institutional based services. The financial situation for the next fiscal year (FYE 6/30/12) does not really appear any better. DMH will be addressing funding for that fiscal year during the legislative session that will begin in early January 2011.

Goal: To increase funds available for community services for adults with serious mental illness.

Objective: The DMH will seek additional state funds for community mental health services for adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Funding Increase Request

Indicator: The Department of Mental Health will seek additional funds in its FY 2012 budget request for community support services for adults with serious mental illness.

Measure: Inclusion of request for increased state funds to support community mental health services for adults in the FY 2012 DMH Budget Request.

Source(s) of

Information: DMH Budget Request, FY 2012

Special

Issues: Based on the most recent estimated use of funds of 55% for adult services of the total to be requested for adults' and children's community mental health services, this percentage is currently reflected in the projection for additional state matching funds for adult mental health services provided by CMHCs and funded through Medicaid (in preceding projected budget request).

Significance: Increased availability of state funding for community mental health services will positively impact the rate of expansion of the services for which any increase is received.

Funding: State

Staffing - Human Resources, CMHCs:

POSITION	Total Staff
1. Psychiatrists	32
2. Other Physicians	9
3. Psychologists, Ph.D.	13
4. Staff with Master's Degree or Above in Field of Psychology	92
5. Other Psychologists	17
6. Social Worker (MSW, Other Master Degree or Above.	256
7. Other Social Workers	70
8. Registered Nurses (AA or Above)	50
9. Licensed Practical or Vocation Nurses	17
10. Other Mental Health Professionals (Bachelor Degree or Above)	592
11. Other Mental Health Workers (Less that Bachelor's Degree)	518
12. Physical Health Professionals	10
13. All Other Staff (clerical, maintenance, etc.)	390
14. Totals	2066

Funding for Services for Persons with Co-occurring Disorders

In FY 2009 DMH allocated \$1,154,132 from Substance Abuse Prevention and Treatment (SAPT) Block Grant funding to the 15 CMHCs for services to individuals with co-occurring disorders of mental illness and substance abuse; of this amount, \$37,000 was allocated to provide training to all 15 CMHCs. Additional training addressing co-occurring disorders was provided at the 2nd Annual Mississippi School for Addiction Professionals. MSH Division of Community Services was also allocated funding to continue operation of a community-based residential treatment program for individuals with a dual diagnosis. Funding for services to individuals with co-occurring disorders of mental illness and substance abuse will continue in FY 2011, and as described previously, training on integrated assessment and treatment for co-occurring disorders will continue to be implemented with support from the Transformation Transfer Initiative funded by CMHS.

Mental Health Transformation Activities: Workforce Development and Involving Consumers Fully in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)

Training of Mental Health Service Providers

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. As of March 2010, DMH had conducted/facilitated four case management orientation sessions, and 113 case managers had been trained. As noted previously, DMH is drafting updated *Rules and Regulations for the Case Management Certification Program* and intends to pilot an online self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program and the corresponding objective. Providing the case management training program online will provide cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area.

Mental Health Therapist Certification and Licensure Program

The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master's level or above mental health staff members who are employed within Mississippi's state mental health system and who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist Exam and corresponding study guide was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 continuing education (CE) hours of mental health-related training over a two-year period in order to meet biennial renewal requirements. (*Note: the Mental Health Therapist licensure level is no longer available to new individuals, effective January 2009; however, individuals who achieved this level prior to its discontinuance are able to maintain it as long as they continue to meet the renewal requirements.)

Licensed Department of Mental Health (DMH) Administrator Program

The Mental Health Administrators program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master's level or above individuals who hold positions as the top-level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Once an individual enters the Program as a Program Participant, he/she must complete a program of Independent Study/Training to obtain licensure. Two Independent Study/Training Options are currently available: Option One-successful completion of the Mississippi Certified Public Manager program and a series of written examinations based on Mississippi rules/regulations/standards and Option Two-successful completion of the Mississippi Certified Public Manager program and completion of the Department of Mental Health's leadership development program, Focus. After one of these Independent Study/Training options has been met, Program Participants are issued licensure. Once licensed, each individual is expected to accrue at least 40 contact hours of continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification Professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor's level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of Provisional Certification and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, PLACE made a number of changes:

- Began conversion of credentialing information and application forms to a web-based and/or email format. Therefore, PLACE staff no longer track how many application booklets are mailed out.
- Converted the previously required three Mental Health workshops and exams into one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. PLACE provided study materials to applicable programs.
- Changed the Independent Study/Training component for the Licensed DMH Administrator program to offer two options for Program Participants. Within the "exam option," the requirement was changed from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- Changed the training requirement for the Case Management program from three workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.
- Discontinued requiring CEs to move from provisional to full certification or licensure. CEs are only required to renew.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Licensed DMH Administrator Program and the Case Management Certification Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report continuing education hours when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of the number of individuals in the process of pursuing ongoing in-service/training.

Objective: To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Licensed DMH Administrator and Case Management Credentialing program.

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems

- Brief Name:** Number of DMH-certified/credentialed staff
- Indicator:** The number of individuals who hold a credential in the Mental Health Therapist program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE); the number of Program Participants and those holding licensure in the Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.
- Measure:** The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees in the Licensed DMH Administrator program; the number of individuals who hold a credential in the Case Management Professional program. (Note: This measure includes individuals whose credentials have lapsed/expired.)
- Source(s) of Information:** DMH/PLACE database; PLACE staff
- Special Issues:** None
- Significance:** Existing certification/licensure programs implemented by the Department of Mental Health were authorized by the MS State Legislature and approved by the Governor in 1996 and 1997.
- Funding:** State funds

The number of individuals who hold a credential in the Mental Health Therapist program, the number of individuals who are participants in the Licensed DMH Administrator program, and, the number of individuals who hold a credential in the Case Management Professional Program projected for FY 2011 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target/Actual)	FY 2010 (Target)	FY 2011 (Target)
Mental Health Therapists (all levels)	1,733	1,959	1,973/2,161	2,175	
Mental Health Administrators (all levels)	121	122	122/126	125	
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	–	–	-		–

Number of individuals in the Case Management Certification Program (Beginning FY 2006)	367	629/758	607	845	
Number of individuals who hold a credential in the Mental Health Therapist Program					1,275
Number of individuals how are Participants or who hold a credential in the Licensed DMH Administrator Program					97
Number of individuals who hold a credential in the Case Management Professional Program					100

Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in FY FY 2009, with CMHCs and the Community Services Divisions at East Mississippi State Hospital, Mississippi State Hospital and Central Mississippi Residential Center reporting linkages with state universities and/or state community colleges, as well as private colleges. Areas of training/disciplines represented included: community counseling, social work, psychology, counseling education, school counseling, sociology/criminal justice, rehabilitation counseling, education, family and human development, public policy and administration, nursing, family studies, nurse practitioners, counseling social work, counseling psychology, Center for Civic Engagement and Social Responsibility program at a private college, a Faith and Work Initiative at a private college, nursing, marriage and family counseling, industrial counseling, and human services.

The Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) 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 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. Additionally, a rotation in outpatient substance abuse treatment has been developed with Region 8 mental health center. The UMMC Department of Psychiatry 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 toward the end of 2008 for two community mental health centers (in Greenwood and in Clarksdale). They have expanded this service across the Delta region and expect to have all the community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service has set up a 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 is also using the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). 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. In addition, the Department of Psychiatry is looking into

ways of sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

Training of Pre-evaluation Screening for Civil Commitment

Pre-evaluation screening is a step in the civil commitment process, required by state law to be conducted by the CMHCs. Descriptive information from the screening is provided to the court to determine whether or not it is appropriate to proceed with the commitment examination, which by statute, is conducted by either two licensed physicians or a licensed physician and a licensed psychologist, nurse practitioner or physician assistant certified to conduct commitment examinations. This pre-evaluation screening is a component of the process for inpatient and outpatient civil commitments. The DMH requires that all CMHC staff who conduct pre-evaluation screening successfully complete specialized training for certification in this area.

As of March, 2010, two pre-evaluation training sessions, in which 45 individuals were trained, had been held. Two consumers shared their perspectives of going through the pre-evaluation screening process with CMHC staff in the training. HB 1525, which made changes to the civil commitment statutes, was passed during the 2010 Legislative session. Major changes resulting from that legislation included specification and caps on costs of filing of affidavits and on assessment of other fees supporting the civil commitment procedures and other requirements and clarifications designed to streamline and standardize the process across counties and to facilitate access to emergency care. These changes were incorporated into the pre-evaluation training sessions in FY 2010.

Objective: Training for CMHC staff in providing pre-evaluation screening for individuals being considered for civil commitment will be made available.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Pre-evaluation screener training

Indicator: Availability of training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Minimum Standards.

Measure: The number of training sessions in pre-evaluation screening made available by DMH (minimum of four).

PI Data Table A5.3	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
# Pre-evaluation Screening Training Sessions	8 sessions; 134 trained	6	6; 95 trained	4	4

Source(s) of Information: DMH Training Records

Special Issues: None

Significance: The pre-evaluation training is designed to increase uniformity in procedure and to better ensure minimum competence level of staff who conduct screening. This training should enhance the information provided to the court and facilitate communication between mental health providers, consumers and families, and the court system.

Funding: State funds

Training of Emergency Health Workers in the Area of Mental Health

Mental Health Transformation Activity: Improving Coordination of Care among Multiple Systems

Training of Law Enforcement Involved in Emergency Situations

Through planning aimed at improving community-based crisis and emergency services, the need for training of law enforcement was identified as a major need and included in the State Plan. Frequently, law enforcement officers may be among the first emergency personnel on the scene who interact with consumers and families in crisis, and they might also be involved in the civil commitment process. 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. As a result, a curriculum was developed and implemented in 1997 for recruits being trained through the six state law enforcement academies. This curriculum was developed by the Law Enforcement Task Force, made up of family members, consumers, mental health providers and Department of Public Safety representatives. To also address the training needs of experienced law enforcement officers, the Law Enforcement Task Force developed a curriculum for in-service training, through which law enforcement officers currently in the field can receive continuing education credit, which was implemented in 1998. DMH certified trainers from throughout the state have continued to conduct either the recruit or in-service training. Additionally, in the Warden at the Harrison County jail made a video on the importance of communication between law enforcement and community mental health staff. The video's message urges law enforcement professionals to take advantage of law enforcement training provided by community mental health center staff.

In FY 2008 – FY 2010, DMH made funding available to 15 CMHCs to help support provision of law enforcement training. As of March 2010, CMHCs reported 13 sessions had been conducted, with 165 law enforcement officers trained. As noted under Criterion 1, because of budget restrictions, DMH will not continue funding to support the provision of law enforcement training by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers explore other avenues for training for law enforcement and other emergency services personnel and to explore additional opportunities to divert and/or decrease involvement of individuals with mental illness in the criminal justice system.

For example, the DMH is supportive of efforts by the City of Hattiesburg to plan and implement a Behavioral Health Court in Forrest and Perry counties, supported through funding from the federal Bureau of Justice Administration. In FY 2010, the Lauderdale County Sheriff's Department, in collaboration with NAMI-MS, Weems Mental Health Center and a community-based mental health partnership in their community, also applied for a Justice and Mental Health Collaboration Program grant. If funded, the grant will support planning, and potentially, implementation of activities involving screening at booking, pre-release and post-release services, the provision of some mental health services (including aftercare and transition planning), as well as the provision of cross-training of staff working in the criminal justice and mental health systems.

In December 2008, DMH staff addressed the Mississippi Chiefs of Police Conference and the Mississippi Sheriff's Association Conference. DMH staff also addressed the Mississippi Sheriffs' Association in FY 2010. These presentations communicated DMH's desire to collaborate with law enforcement offices to provide education and support services for officers intervening with citizens experiencing mental illness crises.

The DMH reconvened the Law Enforcement Task Force that initially developed the training modules for law enforcement (described above), with the intent to revise the training, if needed, for use with other types of emergency/health personnel. The Law Enforcement Task Force reviewed the Department of Mental Health *Minimum Standards* that require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH. DMH staff continued to monitor implementation of a standard requiring CMHCs to maintain agreements to provide training to local hospitals, as requested. In FY 2008, DMH began collaboration with the Hinds County Sheriff's Department and the Jackson Police Department to establish a CIT program in the Hinds/Jackson area. A Hinds/Jackson CIT Task Force was established in August 2008. In November, 2008, members of that task force participated in a three-day training visit with the Memphis Police Department CIT through the University of Memphis. Legislation to establish the Hinds/Jackson CIT (H.B. 897) was proposed to the Legislature, but provisions pertaining to CIT in the bill did not pass in 2009. In 2010, HB 1049 was passed during the Regular Legislative Session and provides the framework needed for the establishment of Crisis Intervention Teams (CIT) by local jurisdictions statewide; no additional appropriations specifically for that purpose were authorized by the bill. In FY 2011, DMH will continue collaboration with community mental health centers and law enforcement to develop CIT programs.

Note: Additional objectives on training in cultural diversity, family education/support, consumer education/support, and psychosocial rehabilitation programs are described under Criterion 1.

Information Management Systems Development

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 national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the DMH has applied for and received three Mental Health Data Infrastructure Grants (MH-DIG) from the

CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.

As mentioned, 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 contained in the URS tables. DMH submitted the following URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16 (some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, 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 to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2010, efforts continued to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan-related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers' local systems have been problematic in state-level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH - DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined 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. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children's services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser based system for data entry from these organizations.

The DMH Division of Information Systems and Division of Planning staff will continue to participate in CMHS conference calls and national meetings, held regularly to discuss the development of the URS data tables. DMH staff also will communicate regularly with the community mental health centers'/other providers' data managers as progress on development of the URS data tables continues. DMH Division of Information Systems and Division of Planning staff will also continue work with programmatic staff at the state level in the Bureau of Mental Health and at the local provider level to coordinate development of state plan reporting, including National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the *Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2008- FY 2010)*, which will enable the Mississippi Department of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts for the Uniform Reporting System measures, including the National Outcome Measures as required for the CMHS Block Grant program, to identify trends in services and outcomes, and increase the involvement of stakeholders in planning. The goals of the proposed project are to: (1) Refine the central data repository for public mental health system data; (2) Refine the process for collection and reporting of information from consumer and family satisfaction surveys; (3) Improve data quality assurance systems; and (4) Increase accessibility and use of URS/NOMs measures and other mental health system data by the Mississippi State Mental Health Planning Council, DMH staff and other stakeholders involved in planning and system improvement activities. If its application for another three years of funding for the data infrastructure project is approved, DMH will pursue project plans to refine and implement a strategic plan for reporting client-level data for the National Outcome Measures targeted by CMHS, for refining infrastructure and processes for data collection and reporting, as well as for improving data integrity. Through continued data infrastructure development, quality assurance and technical assistance activities described in this proposal, the integrity and completeness of timely, detailed data to support measures for the Uniform Reporting System (URS) tables, including the National Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well as integration of the measures with other quality assurance information, will facilitate state planning and performance improvements across the system of services and supports for individuals with mental illness and their families.

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

Objective: Continue implementation of uniform data standards and common data systems.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Implementation of uniform data reporting across community mental health programs.

Indicators/Strategies:

- 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 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;

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, if funded;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Measure: Progress on tasks specified in the Indicator.

Special

Issues: As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

Significance: Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

Funding: State funds, Federal funds

**Projected FY 2011 CMHS Block Grant Projected Expenditures
by Type of Service for Adults with Serious Mental Illness**

<u>Service</u>	<u>Projected Est. Expend.</u>
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	<u>\$10,870</u>
TOTAL	\$2,205,211

**Projected Allocation of FY 2011 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 Interim Executive Director	\$99,167.14
Communicare 152 Highway 7 South Oxford, MS 38655 Carole B. Haney., Acting 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 Greenville, MS 38704-5365 Richard Duggin Executive Director	\$121,818.00*
Life Help P.O. Box 1505 Greenwood, MS 38930 Madolyn Smith, Executive Director	\$146,453.00*
Community Counseling Services P.O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director	\$130,475.00*
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director	\$134,349.00*

Mississippi

Hinds Behavioral Health Services P.O. Box 7777 Jackson, MS 39284 Margaret L. Harris, Director	\$140,758.13
Weems Community Mental Health Center P.O. Box 4378 Meridian, MS 39304 Maurice Kahlmus, Executive Director	\$138,304.13
Southwest Mississippi Mental Health Complex P.O. Box 768 McComb, MS 39649 Steve Ellis, Ph.D. Executive Director	\$134,603.13
Pine Belt Mental Healthcare Resources P.O. Box 1030 Hattiesburg, MS 39401 Jerry Mayo, Executive Director	\$150,979.13
Gulf Coast Mental Health Center 1600 Broad Avenue Gulfport, MS 39501-3603 Jeffrey L. Bennett, Executive Director	\$136,553.13
Singing River Services 3407 Shamrock Court Gautier, MS 39553 Sherman Blackwell III, Executive Director	\$101,484.14*
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	<u>\$10,870</u>
Total	<u>\$2,205,211</u>

*Corrected reporting errors as reflected in modification to FY 2010 Plan.

Note: A total of \$187,722 (5% of the total award to be spent on services in FY 2011) will be used by the Mississippi Department of Mental Health for administration. It is projected that \$103,491 will be spent for administrative expenses related to adult community mental health services.

Table C. Mental Health Block Grant Funding for Transformation Activities

Transformation Activity	Column 1	Column 2
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the actual or estimated amount MHBG funding that will be used to support this transformation goal in FY 2011
Goal 1: Americans understand that mental health is essential to overall health.		
Goal 2: Mental health care is consumer and family driven.	X	\$264,468
Goal 3: Disparities in mental health services are eliminated.		
Goal 4: Early mental health screening, assessment, and referral to services are common practice.		
Goal 5: Excellent mental health care is delivered and programs are evaluated.	X	\$32,376.52
Goal 6: technology is used to access mental health care and information.		

A wide range of activities are included in Mississippi's overall transformation agenda. The contributions by and partnerships with mental health consumers, family members and various service providers are essential to the transformation of the public mental health services and system.

Goal II: Mental health care is consumer and family driven. The DMH Division of Consumer and Family Affairs (DCFA) plans to use MHBG funds to support a number of consumer and family focused programs in FY 2011 as was done in FY 2010. Funds will be designated to continue promoting meaningful involvement of consumers and family members in the DMH's move toward a recovery and outcomes oriented system. The DCFA has been charged with taking the lead in guiding initiatives that promote principles of recovery in system transformation efforts. Specifically, funds support the National Alliance on Mental Illness-Mississippi chapter (NAMI-MS) to provide training, family education and support activities through their Family to Family curriculum. NAMI will spend time developing an ideal NAMI system model for the State and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education, and support (\$87,602). MHBG funds will also be used to support a drop-in center for consumers in the southern part of the State (\$69,660). Finally, funds will be used for networking with current consumer/advocacy groups for potential membership on advisory councils, and distribution of educational materials to service providers about trainings offered through the Leadership Academy and Recovery Now (\$127,006).

Goal V: Excellent mental health care is delivered and programs are evaluated. Improving the functioning of adults and transition age young adults with serious mental illness receiving services (from their prospective) is a key indicator in assessing progress on other goals designed to improve the quality of services and support recovery-oriented systems change. The Division of Community Services supports the activities of one full-time and two part-time peer specialists, which include

conducting on-site peer reviews and monitoring of community based mental health services. The Division of Community Services and the Division of Consumer and Family Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care that 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.

Additionally, a Recovery Self-Assessment tool was developed to measure the DMH transformation from a traditional mental health service system to a recovery-oriented system of care. One goal of the assessment is to assist stakeholders and service providers to consistently track transformation activities in accordance with the DMH's vision of developing a person-driven, recovery-oriented system of care.

The Bureau of Community Services and the DCFA will continue to explore areas to train and employ Peer Specialists and educate the community mental health systems on their role in the recovery process. It is the intent of the Division to move the mental health system to a wellness model that empowers consumers to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process (\$32,376).

Note: Activities addressing other Transformation Goals (e.g., a statewide anti-stigma campaign, Goal I; planning and training in cultural competence, Goal III; planning and training in providing integrated services for persons with co-occurring disorders, Goal IV; and, telehealth initiatives to provide psychiatric services/consultation and training, Goal VI) are supported through other federal and/or state funds.