

PART D:

Mississippi Department of Mental Health

FY 2009 State Plan Implementation Report

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Report Summary

1. Summary of Areas Previously Identified by State as Needing Improvement

Children's Services

- 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 focus on youth suicide prevention activities, including quarterly meetings of the Youth Suicide Prevention Advisory Council, training on ASIST and safeTALK practices, information dissemination, coordinating workshops and conferences on youth suicide prevention, collaboration with local school districts, and continued implementation of the statewide youth suicide prevention plan.
- 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.
- Increased participation and collaboration with the local System of Care project, commUNITY cares, in the implementation of evidence-based practices, cultural competency training, sustainability, evaluation, and youth involvement.
- Work with the two National Child Traumatic Stress Network sites in Mississippi to promote the provision of trauma-informed care in the public mental health system.

Adult Services

- Continuing efforts to expand crisis intervention services. The Department of Mental Health continued to work with the Mississippi Legislature, which authorized the piloting of one state crisis center (in Grenada), shifting its operation by Mississippi State Hospital to operation by a community mental health center during FY 2010. The DMH plans to further expand this model to all crisis center regions within five years.
- Continuing activities to strengthen family education and support activities.
- Continuing work to strengthen consumer education activities.
- Maintaining availability and continuing efforts to improve 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.
- Maintaining availability, improving the quality through training and technical assistance and facilitating further development of psychosocial rehabilitation services for elderly persons throughout all service regions in the state, including community-based services and services for individuals in nursing homes.
- Creating and maintaining more person-directed case management services for individuals with serious mental illness by incorporating person-centered planning in case management orientation provided by the Department of Mental Health.
- Developing and implementing new protocols for providing intensive case management in all regions of the state.
- Continuing to monitor and refine new case management service options.
- Continuing efforts to implement changes to support specialized programs for persons with mental illness who are homeless.
- Continuing initiatives to improve evidence-based services for individuals with co-occurring disorders of substance abuse and mental illness, including increasing efforts to provide training and address the full integration of services for individuals with co-occurring disorders. In 2009, the Department of Mental Health began statewide training and implementation of the *GAIN Short Screener* in efforts to identify and provide better treatment for individuals with co-occurring disorders.
- Ongoing monitoring of community mental health programs for adults for compliance with minimum standards and the provision of technical assistance as requested by community mental health center regions throughout the state.
- Enhancing the peer review process by the Division of Consumer and Family Affairs, which has been implementing improvements based on feedback from stakeholders in the peer

review process.

- 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.
- Continuing efforts to develop more housing options for persons with serious mental illness, including identification of the need to dedicate a staff position to address this significant need.
- 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 (CMS) that, if approved, would facilitate changes in community-based services to further support resilience/recovery.

2. Most Significant Events that Impacted the State Mental Health System in the Previous Year (from FY 2009 Plan)

Psychiatric Residential Treatment Facility (PRTF) Demonstration Program

The Mississippi Division of Medicaid worked with Mississippi Families As Allies for Children's Mental Health, Inc. and the DMH Division of Children and Youth Services to facilitate forums for families and youth in FY 2006 to gather information on gaps and needs in the community-based service system as part of the CMS-funded Community-Based Treatment Alternatives for Children (CTAC) planning grant implemented by the Division of Medicaid. The Division of Medicaid submitted a proposal in 2006, which was awarded in FY 2007, for the Community Alternatives PRTF Program, to serve youth with serious emotional disturbances, one of 10 PRTF Demonstration Projects approved by CMS; it was funded for approximately \$49 million in Mississippi over a five-year period.

CMS Supported Projects: Person-Centered Planning and Transportation

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 also collaborated with the MS Division of Medicaid has implemented a Rebalancing Initiative funded by CMS to address transportation planning; CMS funding for the project, which ended in September 2008. The goal of this project was to coordinate statewide transportation services for individuals with disabilities by working with state and local transportation services providers to offer an array of transportation services. The Mississippi Transportation Coalition, which was initiated during the Rebalancing Initiative project, continues to meet regularly and seek resources to continue planning and piloting of

strategies for coordinated transportation for individuals with disabilities.

Policy Academy on Juvenile Justice

In 2006, a key outcome of efforts by Mississippi participants in a federally-funded Policy Academy for Youth in Juvenile Justice (held in 2005) was maintenance of strong linkages between interagency partners in the academy. Adolescent case review “A” teams, which are designed to divert youth in the juvenile justice system with mental health and/or substance abuse disorders to services and supports in the community, have been developed. Training for these A teams to function appropriately was developed and provided through a partnership between the Department of Mental Health and the Department of Human Services. Beginning in January 2007, the teams began operating and are available statewide. Additionally, those community-based Adolescent Offender Programs that serve youth in juvenile justice who require community mental health treatment were served through day treatment and other programs, as appropriate, which are available through the regional community mental health centers.

Youth Suicide Prevention Initiative

The Mississippi Department of Mental Health was a recipient of a SAMHSA-funded Hurricane Katrina related Youth Suicide Prevention and Early Intervention Grant; implementation of the project began FY 2007. The Director of the Division of Disaster Preparedness and Response is also the State Project Director for this grant project.

The Mississippi Hurricane Katrina-Related Youth Suicide Prevention and Intervention Project addressed the serious need to strengthen Mississippi’s response to the post-Hurricane Katrina mental health needs by implementing an awareness campaign for suicide prevention and intervention, training gatekeepers in recognizing the signs and symptoms of suicide, training gatekeepers and community partners in how to apply a suicide intervention model, and training mental health clinicians in evidenced-based practices to effectively treat trauma. In an effort to reduce the number of youth suicide attempts, the project included goals structured into three main components:

Awareness

- Increase the awareness of suicide warning signs and risk factors.
- Increase the awareness of the stigma associated with youth suicide and mental illness.

Training

- Provide gatekeeper training and support.
- Provide training in trauma informed evidence-based practices.

Prevention

- Promote the development of statewide and local infrastructures to address youth suicide prevention.
- Prevent youth suicide by effectively addressing trauma experienced by youth

Legislation

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

House Bill 1275, passed in 2001, authorized the establishment of an Interagency Coordinating Council for Children and Youth (ICCCY), 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., continue to participate. The act further established a mid-level Interagency System of Care Council (ISCC) to perform certain functions and advise the ICCCY and to establish a statewide system of local multi-agency (MAP) teams. Senate Bill 2991, passed in 2005 and approved by the Governor, extended the legislation authorizing the ICCCY until 2010 (for another five years).

Senate Bill 2894, passed in 2005, called for the establishment and phasing in of "A" (Adolescent) teams are modeled after MAP teams (described in detail in the State Plan under Criteria #1 and #3). The "A" teams are designed to address System of Care services for nonviolent youthful offenders who have serious behavioral or emotional disorders and will include, at a minimum, a school counselor, a community mental health professional, a social services/child welfare professional, a youth court counselor, and a parent who had a child in the juvenile justice system who committed a nonviolent offense. The legislation also included provisions for emergency medical and mental health screening of youth admitted to juvenile detention centers and if necessary, timely referral for further evaluation and/or treatment. The Division of Children and Youth Services continues to work collaboratively with the Mississippi Department of Human Services Division of Youth Services to assist and support efforts to comply with this legislation related to development of "A" teams.

**3. Purpose State FY 2009 Block Grant Expended – Recipients – Activities
Description**

See Criterion # 5 of this Report of the Implementation Report for Children's Services (p. 100) and Adult Services (p. 190) that follows .

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

(a) FY 2009 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.**

Quality Improvement System Development

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

Objective: To continue the peer monitoring process and technical assistance for children's community mental health services.

Population: Children with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system

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

Indicator: Inclusion of peer monitors for children's community mental health in conjunction with selected site/certification visits to community mental health centers, and technical assistance provided at each site visit additionally, upon request.

Measure: Percentage of site/certification visits that will also include a peer monitoring visit (At least 50% of community mental health center provider site/certification visits.)

Comparison/Narrative:

In FY 2008, peer monitors for children's services participated in reviews at four CMHC sites (Regions 13, 10, 12, and 6). In FY 2008, the Department of Mental Health's newly established Division of Consumer and Family Affairs assumed responsibility for peer reviews for the Division of Children and Youth Services and the Division of Community Services for Adults. The new Division conducted

a survey of the 15 community mental health centers, community programs operated by two state hospitals, peer reviewers and other interested stakeholders regarding the effectiveness of the peer review process. The Division suspended all peer reviews temporarily while it is implementing efforts to address concerns indicated by survey results; therefore, the targeted number of peer reviews for children's services for FY 2008 was reduced in a State Plan modification from 50% to 35% of providers for the remainder of this plan year. Once improvements to the peer review process are implemented, peer review visits will resume.

In FY 2009, peer monitors for children's services participated in reviews at seven CMHC sites (Regions 1, 8, 10, 12, 13, 14, and 15). Peer reviews involved six peer reviewers. Of the six reviewers, two were family members, three were professionals and one was a consumer.

Source(s) of Information: Peer Monitoring schedules/reports.

Special Issues: Peer monitors for children's services are invited to participate in most scheduled visits; however, occasionally they may not be able to attend because of unavoidable schedule conflicts. In most cases, a substitute for the visit can be found.

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.

Funding: Federal

Was objective achieved? Yes

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

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 to the survey who respond positively to items in the outcomes domain of the *Youth Services Survey for Families (YSS-F)*

Comparison/Narrative: Not a separate objective in the FY 2008 State Plan. A separate objective was added to the FY 2009 State Plan as part of a modification reviewed by the Planning Council and submitted to CMHS during the year. See Performance Indicator Table that follows for data on perceived outcomes from FY 2007 – FY 2009.

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. DMH had results for all major community services providers for FY 2004; however, since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; complete data was available later in the process. With consultation and approval from CMHS, the *YSS-F* was not administered in 2005 because of 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. As noted, new items were added to the survey instrument for the first time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC) Center for Health Informatics and Patient Safety 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 has been 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 children's services survey was 14%.

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: 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. 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.

Was objective achieved? Yes

**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
% Reporting Positively about Outcomes for Children	66%	65%	66%	69%
Numerator	195 positive responses	198 positive responses	195 positive responses	514 positive responses
Denominator	296 responses	305 responses	296 responses	742 responses

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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
1. % Reporting Positively about Access	90%	87%	90%	90%
Numerator	264 positive responses	264 positive responses	264 positive responses	667 positive responses
Denominator	294 responses	303 responses	294 responses	742 responses

2. % Reporting Positively about General Satisfaction	89%	88%	89%	87%
Numerator	263 positive responses	266 positive responses	263 positive responses	651 responses
Denominator	297 responses	303 responses	303 responses	745 responses
3. % Reporting Positively about Outcomes for Children	66%	65%	66%	69%
Numerator	195 positive responses	198 positive responses	195 positive responses	514 positive responses
Denominator	296 responses	305 responses	296 responses	742 responses
4. % Reporting on Participation in Treatment Planning for their Children	87%	86%	85%	89%
Numerator	255 positive responses	261 positive responses	278 positive responses	662 positive responses
Denominator	294 responses	303 responses	326 responses	741 responses
5. % Reporting High Cultural Sensitivity of Staff (optional)	95%	95%	95%	94%
Numerator	280 positive responses	290 positive responses	280 positive responses	701 positive responses
Denominator	295 responses	305 responses	295 responses	744 responses

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

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).

Comparison/Narrative:

In FY 2008, OCS continued to meet bi-annually (change approved by the Board of Mental Health) with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues brought to DMH's attention concerning mental health services. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly to DMH Central Office staff and the OCS Advisory Council, including four (4) quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk" program to all DMH facilities and community mental health centers (CMHCs), as well as DMH Central Office staff. This directory gives service providers access to basic program/service information for over 2300 programs in FY 2008 and to support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. In FY 2008, 285 new programs were added and over 800 individual programs' information was updated in the reporting period. This process is ongoing.

In FY 2009, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified

program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk". This directory gives service providers access to basic program/ service information for over 2100 programs and support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. Approximately 215 new programs were added and over 600 individual program's information was updated in the reporting period. This process is ongoing. OCS recently contracted with the National Suicide Prevention Lifeline to serve as a network provider. Calls from all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since beginning to take calls in mid December 2008, OCS has received over 2300 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly 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

Was objective achieved? Yes

Mental Health Services

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

Youth Suicide Prevention

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 conducted outside of youth suicide prevention grant activities.

Measure: The number of ASIST, safeTALK training 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 (Target)	FY 2009 (Actual)
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 schools (with special accreditation) in counties in other parts of state (outside coastal counties)	1 ASIST Training, 4 safeTALK, 4 presentations at workshop/seminars	1 ASIST Training; 6 safeTALK trainings; 5 presentations at workshops/seminars

Comparison/Narrative: Not an objective in FY 2008

In FY 2009, DMH staff and other staff from nonprofit service provided one ASIST training to mental health professionals in the Metro Jackson area, six safeTALK trainings to students, faculty, and other support staff including security, dorm assistants, coaches, health center, etc.; and five presentations at workshops/seminars including the MADD Annual Conference, SMHART Annual Conference, CommUNITYcares, JSU Student Leaders and NCADD Recovery

Celebration.

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: Implementation of the Trauma History Timeline upon intake for children/youth with SED receiving services from the Community Mental Health Centers.

Significance: According to Mississippi Department of Health statistics, in 2005, approximately 54 youth ages 15-24 completed suicide, making it the second leading cause of death in Mississippi for this age group.

Was objective achieved? Yes

Additional Information about Outreach Efforts

Examples of specific consultation/education activities and other public education efforts provided at the local level by individual CMHCs and other nonprofit children's mental health programs in FY 2009 to inform the general public, as well as targeted audiences, about children at risk for or with serious emotional disturbances and/or about services available to assist them included: training on mental health-related topics for school and Head Start personnel; meetings with school administrators and board members; radio messages and talk show appearances about mental health issues; participation in community-level task forces (i.e., child abuse task forces, Child Development Councils, Community Resource Councils and MAP teams); consultation/education activities for school staff in meetings or staff development activities; inservice training for parent support groups offered by Families First; presentations at local universities for students and for local civic clubs; consultations with Youth Court counselors and social workers in the Department of Human Services; provision of assistance in linkage with needed services; presentations to parents, faculty and staff about serious emotional disturbances, treatment strategies, parenting issues and classroom management; regular meeting with local school personnel and other governmental entities (e.g., Chancery Clerks, Boards of Supervisors, mayors, city council members, judges, district attorney, and law enforcement); presentations to local PTO's; participation in open houses in local schools; regular visits by case managers to community gatekeepers; regular newspaper articles and participation in television and radio talk shows; participation in parenting classes at a county juvenile detention center; presentation of information through EAPs; participation in the statewide anti-stigma campaign; presentations at local MAP Team meetings and to school administrators and staff (including behavior specialists) presentations to shelter workers, Department of Human Services staff, and Family Court personnel; dissemination of brochures, flyers and other educational materials; provision of

education and services related to stress and trauma to community organizations; participation in community health fairs; educational presentations to community organizations upon request; networking at conferences, communication about programs on web sites; informational booths at Department of Human Services conferences and other presentations at local Department of Human Services offices to front line workers; provision of brochures to and meeting with pediatricians and staff in the service area; hosting of an annual conference for professionals working with at risk children; education of local public school system personnel about the needs of youth with serious emotional disturbances, presentations to alternative schools, coordination of “Children’s Mental Health Day” activities, dissemination of information packets on children’s mental health, family and youth support to psychiatrists and residents in training and to other organizations; and, informational presentations to area business as part of local United Way campaign efforts.

Prevention/Early Identification and Intervention Services

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

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

Population: Children and youth with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Prevention/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. (Three programs: two for teen parents; one for families of children/youth at-risk for or with SED.)

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

Comparison/Narrative: In FY 2008, DMH provided funding to three prevention/early intervention programs: Vicksburg Child Abuse Prevention Center (CAP), which has served 154 children from 65 families; Family Support Center for Metro Jackson, which served 778 children

from 977 families and Vicksburg Family Development Center, which served 173 children from 180 families for a total of 1105 children from 1222 families.

In FY 2009, DMH continued to provide funding to three prevention programs. 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. DMH will continue to fund Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center.

Source(s) of

Information: DMH RFPs/grant applications/grants.

Special

Issues: One of the programs funded at the beginning of FY 2009, the Family Support Center for Metro Jackson, went through a number of organizational and programmatic changes that ultimately resulted in the discontinuation of DMH funding this program.

Significance: These programs provide specialized prevention/early intervention services for targeted at-risk groups, including teen parents.

Funding: State and local funds, and other grant funds as available

Was objective achieved? Yes

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.

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.

Comparison/Narrative: In FY 2008, seven CMHCs and Catholic Charities had 44 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts were provided to six CMHC regions (3, 4, 6, 8, 10 & 12) to encourage providers to

make children's mental health services available to serve children with SED under the age of six years.

In FY 2009, eight CMHCs and Catholic Charities had 74 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts were provided to eight CMHC regions (4, 6, 8, 9, 10, 12, 14 and 15) to encourage providers to make children's mental health services available to serve children.

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 to provide identification of problems and intervention as early as possible.

Funding: Federal, state, and local

Was objective achieved? Yes

Diagnosis and Evaluation Services

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.

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

School-based Day Treatment continued to be available in FY 2009, and the Division of Children and Youth Services provided technical assistance to school-based day treatment programs as needed. During FY 2009, CMHCs reported a total of 354 day treatment programs, with 112 center-based programs and 242 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

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 (Target)	FY 2009 (Actual)
Availability of School-based Outpatient Services (Offered to schools)	Provided in 15 CMHC Regions	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions

Comparison/Narrative: In FY 2008, a total of 25,285 children were reported as having received outpatient services through the 15 community mental health centers (center-based and school-based sites), including individual, group, or family therapy services; CMHCs reported having 662 school-based outpatient therapy sites.

In FY 2009, DMH Minimum Standards required 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. In FY 2009, a total of 26,348 children were reported as having received

outpatient services through the 15 community mental health centers (center-based and school-based sites), including individual, group, or family therapy services; CMHCs reported having 715 school-based outpatient therapy sites. (Note: The number of school-based sites reported span parts of two school years.)

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: Revisions to 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

Was objective achieved? Yes

Objective: To make available funds for two specialized multi disciplinary sexual abuse intervention/treatment programs.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Specialized sexual abuse programs funded

Indicator: The number of specialized multi disciplinary sexual abuse intervention/treatment programs to which DMH makes funding available.

Measure: Count of programs to which DMH makes available funding for multi-disciplinary sexual abuse (at least two).

PI Data Table C1.7	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
Multi-disciplinary Sexual Abuse Programs Funded	2 programs funded; served 174 children	2 programs funded	2 programs funded	2 programs funded served 120 children

Comparison/Narrative: In FY 2008, DMH continued to fund Pine Belt Mental Healthcare Resource and the Vicksburg Family Development Services for specialized multi-disciplinary sexual abuse prevention/intervention. In FY 2008, Vicksburg Family Development Services

served 122 children from 72 families, and Pine Belt Mental Healthcare Resources served 80 children from 80 families for a total of 202 children served.

In FY 2009, DMH continued to fund Pine Belt Mental Healthcare Resource and the Vicksburg Family Development Services for specialized multi-disciplinary sexual abuse prevention/intervention. In FY 2009, Vicksburg Family Development Services served 72 children, and Pine Belt Mental Healthcare Resources served 48, for a total of 120 youth served.

Source(s) of

Information: Division of Children/Youth Services Monthly Report Form

Special

Issues: None

Significance: These two specialized programs collaborate 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. Both programs participate 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 these two programs receive prompt evaluations 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: Local, state, Medicaid, CMHS block grant

Was objective achieved? Yes

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

Therapeutic Nursing Services

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 (Target)	FY 2009 Actual
Regions w/ DMH Funding for Intensive Therapeutic Nursing Programs	2 regions funded	2 regions funded	2 regions funded	2 regions funded

Comparison/Narrative:

In FY 2008, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2008, Region 4 nurses made 17,752 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 provided 24,911 contacts, which included nursing assessments, medication monitoring and physical observations for those children receiving outpatient services.

In FY 2009, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2009, Region 4 nurses 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 provided 26,202 contacts, which included nursing assessments, medication monitoring and physical observations for those children receiving outpatient services.

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

Was objective achieved? Yes**Respite Services**

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 (50)

PI Data Table C1.9	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# 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.		43 respite providers (of which 20 were new) trained by MS FAA; Harden House trained 66 respite providers (of which 47 were new)
# Respite Providers Available			50	239

Comparison/Narrative: In FY 2008, the DMH Division of Children and Youth Services continued to provide funding to Mississippi Families As Allies for Children's Mental Health, Inc. (MS FAA) for respite services. During the year, MS FAA provided training to 22 respite providers (all new providers), and reported serving 159 youth; MS FAA reported 34 total respite providers available statewide. DMH also provided funding to Harden House, which provided respite training to 64 providers (all new providers) and reported serving 118 youth in respite

services in FY 2008; Harden House reported 95 respite providers available through their program.

In FY 2009, the DMH Division of Children and Youth Services continued to provide funding to Mississippi Families As Allies for Children's Mental Health, Inc. (MS FAA) for respite services. During the year, MS FAA provided training to 43 respite providers (of which 20 were new providers), and reported serving 140 youth; MS FAA reported 62 total respite providers available statewide. DMH also provided funding to Harden House, which provided respite training to 66 providers (of which 47 were new providers) and reported serving 272 youth in respite services in FY 2009; Harden House reported 177 respite providers available through their program

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

Was objective achieved? Yes

Housing

Community-Based Residential Treatment Services

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

Therapeutic Foster Care (TFC) Services

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

Objective: 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.

Brief Name: Therapeutic foster care programs funded

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.)

Comparison/Narrative: In FY 2008, DMH continued to make funding available to Catholic Charities, Inc to help support 24 licensed therapeutic foster care homes. Catholic Charities provides therapeutic foster care to 27 youth in FY 2008. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 187 youth.

In FY 2009, DMH continued to make funding available to Catholic Charities, Inc to help support 24 licensed therapeutic foster care homes. Catholic Charities provides therapeutic foster care to 17 youth in FY 2009. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 205 youth. Twelve certification, follow up and/or technical assistance visits were made to the six therapeutic foster care providers.

Source(s) 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 that follows. 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. In FY 2009, 222 children/youth with serious emotional disturbances received therapeutic foster care services; of this total, 17 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. It should be noted that therapeutic foster care is primarily funded by the MS Department of Human Services (DHS). See also “Was objective achieved” below.

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.

Funding: State and local funds, SSBG funds, federal discretionary, and/or other grant funds, as available. Additional funds will continue to be available from private nonprofit contributions and foundations.

Was objective achieved? No; 17 youth were served, rather than the 23 targeted for FY 2009. Factors identified by the provider as related to a lower number being served included difficulty recruiting homes for teens (over 13 years of age), with more severe behavior problems; closure of several homes during the year because of inability to provide a service; and, closure of the Our House Shelter program and transitioning to the Host Home Program, a community-based model that was placed under the therapeutic foster care umbrella. Plans are to certify an additional 25 homes by the end of FY 2010.

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
Percentage of youth receiving therapeutic foster care services (in DMH-funded/certified program only)	.08	.09	.10	.06
Numerator: Number Receiving Therapeutic Foster Care Services	24	27*	23*	17
Denominator: Number of Children with SED Served in DMH Certified/Funded	28,939	29,269	21,000	30,199

Community Mental Health Programs				
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Therapeutic Group Homes

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 (Target)	FY 2009 (Actual)
# Funded Therapeutic Group Homes	13	12	Nine	Nine

Comparison/Narrative: In FY 2008, a total of 209 children and youth with serious emotional disturbances were served by Therapeutic Group Homes funded by DMH. Three therapeutic group homes operated by St. Francis Academy (ABLE I, II, III) served children only part of the year, since they were closed during the reporting period.

- ABLE I, ABLE II, ABLE III, (three homes) Therapeutic Group Homes for Dually Diagnosed Boys (MR/EMD), Picayune, operated by St. Francis Academy for part of FY 2008 before closing (14 served)
- Hope Haven Crisis Residential Therapeutic Homes, Jackson operated by Catholic Charities (86 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (29 served)
- The ARK, Jackson, dually-certified therapeutic group home and community-based residential chemical dependence treatment program, operated by MS Children's Home Society and Family Services Association (served 40)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (served 21)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (served 19)

Also, an additional 201 youth were reported as served through therapeutic group homes certified, but not funded by DMH:

- Therapeutic Group Home (males) operated by Center for Family Life Extension, Inc. (15)
- Fondren Village, Inc. (males) group homes, operated by Fondren Village, Inc. (12)
- Millcreek Therapeutic Group Home (males) operated by Millcreek Rehabilitation Center (48)
- Paul's Home for Children (males) group home, operated by Paul's Home for Children, Sturgis (14)
- The Taylor House Group Home, (males) , operated by The Taylor House Group Home Inc., Greenville (12)
- Bass Group Home (females), Clarksdale, Gulf Coast Girls (females) Gulfport McCarty House (males) Ellisville, McRae Home (females) Jackson and Pendleton Home (Natchez) operated by United Methodist Ministries for Children and Families-(males and females) (74)
- Savior of Life (females), in Jackson (11)
- Saint Joshua's Therapeutic Group Home (males), in Jackson (15)

In FY 2009, DMH continued to make funding available for nine therapeutic group homes. A total of 219 children and youth with serious emotional disturbances were served by therapeutic group homes receiving funding from DMH.

- Hope Haven Crisis Residential Therapeutic Homes, Jackson operated by Catholic Charities (99 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (29 served)
- The ARK, Jackson, dually-certified therapeutic group home (two homes) and community- based residential chemical dependence treatment program, operated by MS Children's Home Society and Family Services Association (served 53)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (served 16)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (served 16)

Also, an additional 257 youth were reported as served through therapeutic group homes certified, but not funded by DMH:

- Therapeutic Group Home (males) operated by Center for Family Life Extension, Inc. (15)
- Fondren Village, Inc. (males) group homes, operated by Fondren Village, Inc. (27)
- Millcreek Therapeutic Group Homes (two homes) operated by Millcreek Rehabilitation Center (37)
- Paul's Home for Children group homes (two homes in Sturgis and in Columbose), operated by Southern Foundation for Homeless Children (41)

- The Taylor House Group Home, (males) , operated by The Taylor House Group Home Inc., Greenville (17)
- Bass Group Home (females), Clarksdale, Gulf Coast Girls (females) Gulfport McCarty House (males) Ellisville, McRae Home (females) Jackson and Pendleton Home (Natchez) operated by United Methodist Ministries for Children and Families-(males and females) (61)
- Savior of Life (females), in Jackson (19)
- Saint Joshua’s Therapeutic Group Home (males), in Jackson (13)
- Treasure House, operated by Positive Living, Inc. in Jackson (20)
- PALS Transitional Therapeutic Group Homes (two homes, Jackson) (7)

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 2009, DMH continued to certify 18 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.

Was objective achieved? Yes

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, as well as through local nonprofit community and faith-based organizations. 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 services 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 three 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 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 in FY 2009 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, therefore, trends will continue to be tracked for another year (in FY 2009) to better inform target setting in subsequent Plan years.

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 three specialized programs serving homeless children/youth with SED, described in separate objectives under Criterion 4 in the State Plan. Provision of partial funding for an Outreach Coordinator at Our House “Host Home” program facilitates outreach and identification of youth in need of comprehensive services because of their homelessness, including youth with serious emotional disturbances. 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 provides services to 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 in FY 2005 through FY 2009.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
Performance Indicator				
% of youth reported homeless/in shelters	.2%	.25%	.2%	.33%
Numerator: # youth reported homeless/in shelters by DMH certified/funded providers	63	78	63	104
Denominator: # All youth reported with living situations by DMH certified/funded providers, excluding Living Situation Not Available	29,622	29,622	29,622	31,754

Was objective achieved? No, the percentage increased slightly. The number of youth reported as homeless/in shelters, since collected from certified/funded mental health providers, might also reflect an increase in access to mental health services for this population.

Services to Special Populations

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

- 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
- 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 local MAP Teams.

Comparison/Narrative: In FY 2008, a Division of Children and Youth Services staff member continued to participate on the Fetal Alcohol Spectrum Disorders (FASD) Task Force, the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-Occurring Disorders Coordinating Committee, and the Underage Drinking Task Force. Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK, Sunflower Landing, and the CART House, which serve youth with co-occurring disorders.

In FY 2009, a Division of Children and Youth Services staff member continued to participate on the Fetal Alcohol Spectrum Disorders (FASD) Task Force, the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-Occurring Disorders Coordinating Committee, and the Underage Drinking Task Force (MAAUD). 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. Bureau of Alcohol and staff are members of the FASD Task Force. A Division of Children and Youth staff member provided FASD education at Fairland substance abuse treatment facility, which serves pregnant women and women with children. Division of Children and Youth staff participated in the DMH's Annual School for Addiction Professionals.

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.

Funding: Federal and state

Was objective achieved? Yes

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 (Target)	FY 2009 (Actual)
FASD screenings conducted	Not an objective in the FY 2008 State Plan, but it is estimated that 1,848 screenings will be conducted	800	1,231

Comparison/Narrative: Not an objective in FY 2008

In FY 2009, the CMHCs screened 1,231 children ages birth to seven to identify those children who needed to be referred to the Child Development Center at UMMC for a full FASD diagnostic evaluation.

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 CMH 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

Was objective achieved? Yes

Objective: The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned for FY 2009.

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

Comparison/Narrative: In FY 2008, a designated Children and Youth Services staff member continued to participate on the Co-Occurring Disorders Coordinating Committee. Additionally, the System of Care Project (CommUNITYcares), now in its second year of implementation and serving children/youth with SED and/or co-occurring SED and substance misuse in Forrest County, had several workshops specifically addressing co-occurring disorders; topics such as cognitive behavioral therapy techniques, strength-based wraparound approaches, and *The Seven Challenges* program were included. In January 2008, a two-day intensive training was provided to therapeutic group home providers and staff that addressed the screening, assessment and treatment of youth with SED and alcohol/drug abuse disorders. Also, the 1st Annual Mississippi School for Addiction Professionals held 1/29/08-2/1/08, provided several break out sessions on youth with co-occurring disorders

The SCATTC (Southern Coast Addiction Technology Transfer Center) provided a one-day workshop specifically addressing identification and/or treatment of youth with co-occurring disorders of serious emotional disturbance and substance abuse on June 10, 2008. The Annual Lookin' To the Future Conference held in July 2008 provided sessions on youth with co-occurring disorders.

In FY 2009, a designated Children and Youth Services staff member continued to participate on the Co-Occurring Disorders Coordinating Committee. Additionally, the System of Care Project (CommUNITYcares), now in its third year of implementation and serving children/youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar Counties, continues to provide workshops specifically addressing co-occurring disorders; topics such as cognitive behavioral therapy techniques, strength-based wraparound approaches, and *The Seven Challenges* program were included. The 2nd Annual Mississippi School for Addiction Professionals held 1/20/09-01/23/09, provided several break out

sessions on youth with co-occurring disorders. Additionally, the Annual Lookin' To the Future Conference held in July 2009 provided sessions on youth with co-occurring disorders.

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

Special Issues: Division of Children and Youth Services staff members will continue to collaborate with the Division 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 Co-occurring Disorders Conference to be held in FY 2009.

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

Was objective achieved? Yes

Community-based Residential Treatment Programs for adolescents with substance abuse

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 2009.

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 (Target)	FY 2009 (Actual)
# Beds Funded Residential Treatment Program	56 beds available; 175 youth served	146 youth served in 56 beds	56 beds available	137 youth served in 56 beds

Comparison/Narrative:

In FY 2008, the three programs served 146 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in a community based residential treatment. Sunflower Landing served 60 youth; CART House served 36 youth; and, the ARK served 40 youth.

In FY 2009, the three programs served 137 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in a community based residential treatment. Sunflower Landing served 53 youth (50 of whom had co-occurring disorders); CART House served 35 youth; and, the ARK served 49 youth, 46 of whom had co-occurring disorders).

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

Was objective achieved? Yes

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

Multicultural Task Force

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 2009 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council.

Comparison/Narrative: In FY 2008, the Multicultural Task Force met seven times (November 16 and December 7, 2007, and February 15, March 21, April 18, June 20, and August 15, 2008). A Peer Specialist from the DMH and a Public Relation Director from Central Mississippi Residential Facility joined as new members. The task force organized the statewide Day of Diversity held on October 13, 2007; a staff member was a guest on WLBT (a local television station) on October 9, 2007 to discuss the event. On October 16, 2007, a staff member conducted a cultural competency presentation at the Department of Health's Regional Health Disparity Summit I at Alcorn State University. The task force provided its annual report to the Mississippi State Mental Health Planning Council on August 14, 2008.

In FY 2009, the Multicultural Task Force (MCTF) met on November 21, 2008, June 22, 2009, August 17, 2009, September 14, 2009. The task force organized the statewide Day of Diversity held on October 13, 2008; on November 3, 2008, the co-chair of the MCTF presented at the 27th Annual MH/MR Joint Conference on cultural competency and disparities. On April 17, 2009, the "Cultural and Linguistic Competency: Keeping It Real" workshop was held. The presenter was Dr. Vivian Jackson with the National Center for Cultural Competency. Approximately, 85 service providers attended the workshop. The annual report of task force activities was made to the Mississippi State Mental Health Planning and Advisory Council on August 17, 2009.

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

Was objective achieved? Yes

Local Provider Cultural Competence Assessment

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.

Comparison/Narrative:

The long-range goal of the cultural competence assessment 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 2008, Region 11 staff completed the cultural competency assessment on May 16, 2008. The region had not received the results at the end of FY 2008 due to technical issues in generating the report document.

In FY 2009, Region 11 CMHC received their cultural competence assessment results on May 8, 2009. Staff member met with staff from Region 2 CMHC on July 21, 2009, to discuss the cultural competency assessments. Staff has not yet received a date to conduct the assessment from the Region 1 CMHC clinical director.

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

Was objective achieved? Yes

Mental Health Transformation Activities: Support for Culturally Competent Services and Workforce Development (NFC Goal 3.1)

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.

Comparison/Narrative: The Multicultural Task Force, which includes a representative of the Division of Children and Youth Services, continued to meet in FY 2008 to identify priority areas to be addressed related to cultural issues in community mental health service delivery. In FY 2008, the Department of Mental Health continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model. Children/youth service providers had the opportunity to participate in their local CMHC Day of Diversity activities in October 2007. The Mississippi Alliance for School Health (MASH) annual conference (co-sponsored by DMH) offered three sessions on cultural diversity that focused on local health issues in Choctaw Indian youth, medical care for children with special needs, and school health issues in rural Mississippi. Diversity training was provided to MS Families As Allies, Inc.

In FY 2009, 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. The DMH continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model. Children/ youth service providers had the opportunity to participate in their local CMHC Day of Diversity activities in Oct. 2008. 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. Three NCBI trainings were conducted at Region 8 (Copiah County, Rankin County and Simpson County) in April 2009. An NCBI training was provided to Region 3 Mental Health Center staff in April 2009. In May 2009, staff conducted a cultural diversity training session at the Consumer Conference. NCBI training was also conducted for MS Families As Allies for Children's Mental Health, Inc. in June 2009. An NCBI training was conducted at Region 1 Mental Health Center in September 2009.

The *DMH Minimum Standards for Community Mental Health/Mental Retardation Services* continued 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 continued to require additional assurances from providers with which it contracts that training addressing cultural diversity and/or sensitivity will be provided.

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

Was objective achieved? Yes

Mental Health Transformation Activity: Improving Access to Employment

Rehabilitation and Employment Services

Rehabilitation services are available to youth (within the last two years of existing 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. The distinguishing difference between eligibility for these specialized services and general vocational rehabilitation services is the youth's potential for a specific vocation. Supported employment is a specialized vocational rehabilitation service available to youth and adults in the state. The focus group for this service is individuals who demonstrate more severe disabilities. Additionally, they are individuals who demonstrate that they 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 served 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. In September 2003, the Mississippi Department of Rehabilitation was awarded a national Social Security demonstration project grant designed to assist youth, ages 10 -25, in becoming employed through transition interventions from school to work and to reduce reliance on public benefits. (See Criterion #3, section on Initiatives to Assure Transition to Adult Mental Health Services for more detailed information on this project.). This five-year grant ended in September 2008; however, a no-cost extension was approved. Sustainability efforts between partners are being coordinated, and all plans were projected to be in place before September 2009.

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

In Mississippi, substance abuse prevention and treatment services are also administered by the MS Department of Mental Health through its Bureau of Alcohol and Drug Abuse (BADA). Community mental health centers are the primary providers for both community mental health and outpatient substance abuse treatment for youth. As indicated previously and described further under Criterion #3, the two bureaus have increased collaborative efforts to better address the needs of youth with dual diagnosis of mental illness and substance abuse. Specific objectives addressing this group of youth were described previously under the section on Special Populations under this criterion. 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. Primary prevention services are provided through 15 community mental health/mental retardation centers and 13 other community-based private/public nonprofit free-standing organizations. All 28 programs use their funding to provide direct services to the mental health regions in which they reside. By funding all 15 Community Mental Health Centers, BADA ensures all 82 counties are provided prevention services.

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 March, 2008 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.

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

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. 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. At the conclusion of FY 2008, there were 10,377 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 2008, there were 1,412 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 2008, there were 1,138 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 2008, there were 3,338 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 2008, there were 827 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 2008, there were 4,166 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 2008, the Office of Constituency Services received and processed approximately 2,378 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 2008, 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 2008, vocational services were provided to 124 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 2008, 10,991 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 2008, there were 2,656 individuals who were admitted to a DUI program and 1,698 inmates admitted to 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 52 licensed and/or Certificate of Need (CON) approved beds in FY 2008 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 (CHIP Phase I, a Medicaid expansion program, and CHIP Phase II, a separate insurance program.) CHIP Phase II of MS Health Benefits Program was approved to increase income eligibility to 200% of the federal poverty level in December, 1999, and was implemented January 1, 2000. The same application is used by individuals to apply for Mississippi Medicaid and the separate insurance program. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP. It was originally estimated that 15,000 uninsured children would be eligible for Medicaid expanded and 85,000 for CHIP. From monitoring reviews of Division of Medicaid data and enrollment data, more children are being determined eligible for Medicaid. Current CHIP enrollment is over 67,000 children.

In families with income under 200% of the poverty level, uninsured children under the age of 19 are eligible for CHIP. As of January 1, 2005, determination for eligibility for Mississippi Health Benefits was transitioned from the Department of Human Services to the Division of Medicaid. At that time, the requirement for a face-to-face interview for application and redetermination was required. The following information must also be made available for all persons applying: proof of household income, proof of citizenship and identity and Social Security numbers for all applying. 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. Also, under the CHIP plan, the six-month waiting period for children with previous creditable health insurance was eliminated in October,

2000. The program currently has zero waiting periods, meaning that the applicant must be without other health insurance at the time of application. The state must monitor the number of children enrolled since this policy change who have had health insurance coverage in the last six months. When that number is 15% of the number of children enrolled since October, 2000, the state must implement a crowd-out mechanism, such as a waiting period with specific exceptions. At such time, the state will survey families of children who have lost coverage in the last six months to identify the reason for lost or discontinuance of coverage. Results will be used to define possible exceptions to the waiting period.

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 152 delivery sites in Mississippi, further advancing President Obama's effort to provide access to health care for all Americans. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers. 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. 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. 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. 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 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

Outreach and Expansion of Case Management Services

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 (11,000)

PI Data Table C1.14	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# SED Receiving Case Management*	15,011	14,995	11,000	14,666

Comparison/Narrative: In FY 2008, 14,995 children with serious emotional disturbance, including children receiving Medicaid, were reported as having received case management services through the CMHCs. In FY 2008, 300 CMHC case managers provided services to children/youth with SED; 87 of these case managers were reported to also have served adults.

In FY 2009, 14,666 children with serious emotional disturbance, including children receiving Medicaid, were reported as having received case management services through the CMHCs. In FY 2009, 300 CMHC case managers provided services to children/youth with SED; 82 of these case managers were reported to also have served adults.

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 within the FY 2008-2009 time period, 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

Was objective achieved? Yes

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.

Activities To Reduce Hospitalization

Community-Based Emergency Response/Crisis Intervention

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 (Target)	FY 2009 (Actual)
# Funded Crisis Response Programs	5	5	5	5

Comparison/Narrative:

In FY 2008, the DMH continued to fund five comprehensive crisis response programs for youth with SED or behavioral disorders. Catholic Charities (Hope Haven) continued to target Hinds County and the surroundings area. Hope Haven includes five crisis residential beds on a regular basis, with potential capacity of up to seven beds. The second model, operated by Community Counseling Services in Region 7, continued include a mobile crisis line, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. The third model, operated by Pine Belt healthcare resources in Region 12, 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. The fourth program, Region 8 Community Mental Health Center, received funding to offer management and psychiatric/therapeutic nursing services to children/youth with SED and their families. These comprehensive crisis response programs continued participation on MAP teams and in other activities described above. A fifth smaller program, Region 4 (Timber Hills Mental Health Services) implemented a mobile crisis response team, consisting of seven, experienced Bachelor's level case manager with knowledge in crisis intervention, one Master's level therapist on call 24 hours a day for all four counties, and three Master's level coordinators on-call 24 hours a day. A mobile crisis team serves all the counties in Region 4, with at least two team members per county.

In FY 2009, the DMH continued to fund five comprehensive crisis response programs for youth with SED or behavioral disorders. Catholic Charities (Hope Haven) continued to target Hinds County and the surroundings area. Hope Haven includes five crisis residential beds on a regular basis, with potential capacity of up to seven beds. The second model, operated by Community Counseling Services in Region 7, continued include a mobile crisis line, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. The third model, operated by Pine Belt healthcare resources in Region 12, 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. The fourth program, Region 8 Community Mental Health Center, received funding to offer management and psychiatric/therapeutic nursing services to children/youth with SED and their families. These comprehensive crisis response programs continued participation on MAP teams and in other activities described above. A fifth smaller program, Region 4 (Timber Hills Mental Health Services) implemented a mobile crisis response team, consisting of seven, experienced Bachelor's level case manager with knowledge in crisis intervention, one Master's level therapist on call 24 hours a day for all four counties, and three Master's level coordinators on-call 24 hours a day. A mobile crisis team serves all the counties in Region 4, with at least two team members per county.

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

Was objective achieved? Yes

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 (Target)	FY 2009 (Actual)
# Funded Intensive Crisis Intervention Projects	5	5	5	5

Comparison/Narrative:

In FY 2008, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. In FY 2008, Region 3 CMHC served 116 youth; Region 13 served 401 youth; Region 15 served 23 youth; Gulf Coast Women's Center served 77 youth; and MS Families as Allies for Children Mental Health, Inc. served 131 youth.

In FY 2009, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. Region 3 CMHC served 227 youth; Region 13 served 301 youth; Region 15 served 45 youth; Gulf Coast Women's Center served 44 youth; and MS Families as Allies for Children Mental Health, Inc.

served 283 youth.

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

Was objective achieved? Yes

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

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 Target	FY 2009 Actual
# Family Education Groups	8 family education/support groups available through MS FAA (Hinds, Rankin, Madison, Yazoo, DeSoto, Forrest,	68 family education/support groups were available through MS FAA (Hinds, Rankin, Madison, Yazoo, Desoto,		89 family education/support groups were available through MS FAA at 14 locations (Hinds, Rankin, Madison,

Mississippi

	Harrison and Hancock); 166 families received services from 8 family support specialists at MS FAA.	Forrest, Lamar, Jones, Harrison, and Hancock counties)		Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, Marion, Adams, Jackson, Warren, 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 provided by NAMI-MS in 4 regions	MS FAA provided 25 family workshops/training opportunities with 220 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS	15	MS FAA provided 20 family workshops/training opportunities with 247 participants; five Parent to Parent (NAMI Basis) classes with 40 participants (20 meetings/192 contacts) provided by NAMI-MS

Comparison/Narrative:

In FY 2008, DMH continued to make funding available for family education and family support. In FY 2008, Mississippi Families As Allies for Children’s Mental Health made available 8 family education/support groups (serving people from Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, and Hancock, Desoto and Jackson counties) and provided 25 family workshops and training opportunities involving 220 participants. NAMI-MS has replaced Visions for Tomorrow and Parent to Parent classes with NAMI-Basics.

In FY 2009, DMH continued to make funding available for family education and family support. In FY 2009, Mississippi Families As Allies for Children’s Mental Health, Inc. made available 89 family education/support groups (serving people from Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, Marion, Adams, Hancock, Desoto and Jackson 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. There were five Parent to Parent (NAMI Basics) classes with 40 participants (20 meetings/192 contacts) and 24 Parent Support Meetings with 152 participants in FY 2009.

Source(s) of

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

Special

Issues: None

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

Funding: Federal and state funds

Was objective achieved? Yes

Other Activities Leading to Reduction of Hospitalization

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

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 for FY 2004- FY 2008. 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 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 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 in FY 2009 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 for another year (in FY 2009) 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. 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 state psychiatric hospitals will provide routine reports on the number of readmissions by county to community mental health centers. Other planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will also be continued.

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual (Preliminary)	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	1.3%	1.3%	1.25%	.25%
Numerator: Number of civil readmissions to any state hospital within 30 days	5	5	5	1
Denominator: Total number of civil discharges in the year	384	375	400	402
2. Decreased rate of Civil Readmissions to state hospitals within 180 days	5.99%	5.6%	6%	5.47%
Numerator: Number of civil redmissions to any state hospital within 30	23	21	24	22

days				
Denominator: Total number of civil discharges in the year	384	375	400	402

Note: These results are also reported in the FY 2009 URS Table 20A and 20B submission; results may be modified after review/edits by the National Research Institute (NRI) and the MDMH.

Was objective achieved? Yes

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. DMH had results for all major community services providers for FY 2004. Since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; however, complete data was available later in the process. With consultation and approval from CMHS, the *YSS-F* was not administered in 2005 because of 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. As noted, new items were added to the survey instrument for the first

time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC), Center for Health Informatics and Patient Safety 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 has been 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 at six-months to determine the implementation of their plan of correction on any deficiencies noted in the certification /site visit.

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
% age of Families of children/adolescents reporting positively regarding social connectedness	83%	85%	84%	87%
Numerator: Number of families of children/adolescents reporting positively about social connectedness	243	259	260	646

Denominator: Total number of family responses regarding social connectedness	294	305	308	741
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Was objective achieved? Yes

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 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).

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. DMH had results for all major community services providers for FY 2004; however, since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; complete data was available later in the process. With consultation and approval from CMHS, the *YSS-F* was not administered in 2005 because of 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. As noted, new items were added to the survey instrument for the first time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH has been working

with the University of Mississippi Medical Center (UMMC) Center for Health Informatics and Patient Safety 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 has been 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 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. 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 Target	FY 2009 Actual
Performance Indicator				
% age of Families of children/adolescents reporting positively regarding functioning	68%	67%	67%	70%
Numerator: Number of families of children/adolescents reporting positively about functioning	200	203	207	520
Denominator: Total number of family responses regarding functioning	296	305	309	744

Was objective achieved? Yes

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

Prevalence in Mississippi

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 2009 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 2009 State Plan.

Comparison/Narrative:

In the FY 2008 and FY 2009 State Plans, Mississippi utilized the 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, updating its estimates using data from the 2000 U.S. Census.

Estimates in the FY 2008 and FY 2009 State Plans were updated from Uniform Reporting System (URS) Table 1: Estimated number of children and adolescents, age 9-17, with serious emotional disturbances by state, 2006 and 2007 respectively, 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 2006 was 385,400, and in 2007 was 382,933.* .Mississippi remains in the group of states with the highest poverty rate (29.6%, ages 5-17 in poverty); 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 2007 and were 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 42,123-49,781
- (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 26,805-34,464

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 2009 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 (132,018**), yielding an estimated prevalence of 12,146 in this transition age group.

* Civilian population aged 9 to 17 were created by the NRI using Census data from 2007 for the numbers of persons aged 5 to 17 and aged 9 to 17. The percent of the 2007 data for aged 5 to 17 that was aged 9 to 17 was applied to the 2007 Census Civilian Population aged 5 to 17 to create the estimated 2007 aged 9 to 17 numbers

** Calculated by Dr. Barbara Logue, Senior Demographer, MS Institutions of Higher Learning, based on 2000 Census data and 2007 Census estimates.

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 National Association of Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS)

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

Was objective achieved? Yes

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.

Quantitative Targets: Number of Children To Be Served

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).

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. (21,000)

PI Data Table C2.1	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# SED Served	28,939	29,269*	21,000	30,199

* There may also be some duplication in totals across the CMHC and other nonprofit programs.

Comparison/Narrative:

In FY 2008, 28,246 children with SED were reported to have been served through the regional community mental health centers, and 1,023 children with SED were reported to have been served through other nonprofit providers certified and receiving funding from DMH; a total of 29,269 youth with SED were served through the public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.

In FY 2009, 29,565 children with SED were reported to have been served through the regional community mental health centers, and 634 children with SED were reported to

have been served through other nonprofit providers certified and receiving funding from DMH; a total of 30,199 youth with SED were served through the public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.

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), to develop a central depository for data from the mental health system. As this system continues to be implemented within the FY 2008-2009 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 children with serious emotional disturbance in FY 2009, 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.

Was objective achieved? Yes

National Outcome Measure: Increased Access to Services

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 in FY 2009 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 2009. As this system continues to be implemented within the FY 2008-2009 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. DMH continued 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 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 in FY 2009 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 for another year (in FY 2009) 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 in FY 2009

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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
Total persons under 18 years served in public mental health system*	30,433*	31,189	30,275	31,821

*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.

** These results were also reported in the FY 2009 URS Tables 2A and 2 B submission; results may be modified after review/edits by the National Research Institute (NRI) and the MDMH.

Was objective achieved? Yes

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 in FY 2003 through FY 2009 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 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.

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)

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 – Second Year: “What a Difference a Friend Makes”

Indicator: To reach 200,000 individuals during FY 2009.

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 (Target)	FY 2009 (Actual)
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2007 Plan	1.3 million individuals reached	200,000	900,000 (approximately)

Comparison/Narrative: Although not an objective in the FY 2007 State Plan document, DMH developed a statewide anti-stigma committee in March 2007. The committee consists of more than 40 representatives statewide from mental health facilities, community mental health centers, colleges, 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 “What a Difference a Friend Makes” campaign.

DMH developed a tracking system for presentations, newspaper/television/radio interviews, and other items for the statewide anti-stigma campaign. Since October 1, 2007 more than 20,000 anti-stigma brochures were distributed statewide. A majority of these brochures were distributed at Mississippi colleges and high schools. Members of the statewide Anti-Stigma Campaign have spoken at high schools and colleges throughout the state including Belhaven College, Mississippi State University Meridian Campus, Jackson State University, Ole Miss, Pearl High School and many more.

In April 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. DMH made more than 25 presentations on the two topics including presentations for youth detention centers, MS Job Corp, National NAMI conference and the Mississippi Alliance for School Health conference. More than 4,000 individuals have been reached with these presentations. In February 2008, more than 1,000 students in Newton County participated in the 1st Mental Health Awareness Day at Central Mississippi Residential Center. The day focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems.

Pearl High School students performed an anti-stigma skit at the annual legislative breakfast to more than 200 audience members. Students also created a DVD of the skit to be shown statewide during presentations. The DVD was unveiled during a DMH anti-stigma presentation at Pearl High School. The DVD and presentation was featured in several newspapers in Central Mississippi. An anti-stigma kickoff/health fair was also held in Meridian in October. More than 400 college students and adults attended the event.

Newspaper articles were printed statewide reaching more than 470,000 readers. A total of 10 television interviews have been conducted including interviews at WLOX in Biloxi, WLBT in Jackson and WTOK in Meridian. More than 386,000 viewers were reached with the television interviews. Committee members also participated in radio interviews statewide. More than 500,000 listeners from north Mississippi to south Mississippi were reached with radio interviews and public service announcements. From October 1, 2007 to September 30, 2008, more than 1.3 million individuals have seen (television interviews), read (newspaper articles/brochures) or heard (radio interviews and presentations) information about the anti-stigma campaign.

In FY 2009, DMH continued to expand its statewide anti-stigma campaign. The anti-stigma committee met four times throughout the year to discuss statewide efforts and to plan for the new anti-stigma campaign which was launched in October 2009. Since Oct. 1, 2008 more than 15,000 anti-stigma brochures were distributed. A majority of these brochures were distributed at Miss. colleges and high schools. Beginning in 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. Since October 1, 2008, DMH made more than 75 presentations on the two topics. Speaking engagements included high schools, middle schools, colleges, school counselors and nurses, and teachers and principals. Displays were set up at conferences statewide including the Governor's Obesity Conference, Jackson State University Mind and Body Fair, Looking to the Future Conference, and the Suicide Prevention Workshop. In January 2009, more than 1,500 students and teachers in Newton County participated in the 3rd Annual Mental Health Awareness Day at Central Miss. Residential Ctr. The day focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems. In May 2009, DMH partnered with MSH and the Rankin County Chamber of Commerce to host the event, "Games Your Children Play" in Rankin county. The conference targeted parents, teachers, caregivers, etc. and discussed issues related to stigma and suicide prevention. More than 90 people attended the event. More than 55 newspaper articles discussing the stigma and suicide prevention were printed statewide since October 1, 2008 reaching more than 900,000 readers. DMH also participated in 12 radio interviews and eight television interviews to discuss stigma.

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

Was objective achieved? Yes

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.

Comparison/Narrative:

In FY 2008, 720 resource directories were disseminated at conferences or meetings as follows: Case Management Orientation, Health Disparity Summit I (Alcorn State University), Voice of Calvary Health Fair, MYPAC providers, MASH Conference, MHCT Module III training, A-Team training, MAP Team Coordinators’ statewide meeting, MS Protection and Advocacy System, Inc., Pre-Evaluation Screening Training, Division of Medicaid (MYPAC providers), Hinds County Department of Human Services, Division of Family & Children Services (MS Dept. of Human Services), Lookin To The Future Conference, Youth Defenders Annual training, MS Coalition on Child Welfare, Youth Suicide Prevention Workshop, MS Families As Allies for Children’s Mental Health, Fetal Alcohol Spectrum Disorder Symposium, Mississippi College

School of Counseling Psychology, and Division of Youth Services (MS Dept. of Human Services). Presentations were made by the DMH Division of Children and Youth Services Staff at the following meeting/conferences/agencies:

CMHT – Module III- Minimum Standards for Children and Youth Services (3)
Module Training-- Case Management Training (3)
A-Team Training
FASD Training (4)
Case Management Orientation (7)
MAP Team Training
Division of Children and Youth Services Overview- Staff Orientation
First Annual Youth Suicide Prevention Workshop
Juvenile Justice Symposium
MS Alliance for School Health Conference
Adolescent Offender Program Training
Therapeutic Group Home Intensive Trainings (3)
MS Alcohol & Drug School for Addictions Professionals
Jackson State University's School of Social Work
Division of Medicaid, MYPAC provider training
Mental Health Association of the Capital Area
Hudspeth Regional Center, Community Services
Annual Consumer Conference
5th Annual FASD Symposium
MS Coalition on Child Welfare
Youth Defenders Annual Training

In FY 2009, 1,036 resource directories were disseminated at conferences, meetings, or to individuals as follows: Piney Woods Health & Resource Fair, Region 13 CMHC, MAP Team Coordinators, A-Team Coordinators, MS Association of Pediatricians, Region 12 CMHC, Region 9 CMHC, MS Health Summit, Clinton Public Schools, Pre-Evaluation Training participants, Region 8 CMHC, Mississippi State Hospital, foster care & adoptive parents, Mt. Nebo Church Health Fair, participants at the MS Counselor's Association training, Mississippi Families As Allies, and Region 11 CMHC, Mississippi Social Work Conference, annual Lookin' To The Future Conference, Life Help Mental Health Center, Millcreek Therapeutic Group Homes, University of Mississippi Medical Center, Gulf Coast Mental Health Conference, Catholic Charities, Inc., and Department of Health Social Workers. Presentations were made by the DMH Division of Children & Youth Staff at the following meetings/conferences/agencies:

FASD 101 and FASD Screening & Referral Trainings
Case Management Orientation (6)
MAP Team 101 Training
Adolescent Offender Programs annual training
Stress Management Workshop for Crisis Teams
U.S.M School of Social Work Fall Colloquium
Therapeutic Group Home and Foster Care training
Mental Health Planning Council
Child Abuse Prevention Press Conference

Cultural Competency Workshop
MS Gulf Coast Youth Suicide Prevention Conference
Mental Health Summit on the Gulf Coast
Children's Mental Health Awareness Press Conference
Annual School Safety Officer Training
Annual Lookin to the Future Conference
Annual FASD Symposium
MS Alliance for School Health Conference
Youth Court Judges & Referees Seminar
Youth Suicide Prevention Workshop
MS Youth Programs Around the Clock (MYPAC) annual training

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.

Was objective achieved? Yes

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

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.

Comparison/Narrative: In FY 2008, informational materials and technical assistance were provided to 897 local schools by community mental health centers.

In FY 2009, informational materials and technical assistance were provided to 822 local schools by community mental health centers.

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 2008. 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

Was objective achieved? Yes

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.**

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 2009 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.)

Provisions for an Integrated Service System

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:

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 2008; revision of the 2006 strategic plan.

Comparison/Narrative:

In FY 2008, the DMH Executive Director was elected chair of the ICCCY, and the Director of the Division of Children and Youth Services was elected chair of the ISCC. The ISCC met on December 12, 2007, February 21, 2008, May 21, 2008, and August 13, 2008. During the meetings, the System of Care Strategic Plan was updated, cross-training efforts were discussed, the interagency agreement was updated, and a new chair was elected. The ICCCY met on March 14, 2008, and was updated on the System of Care project, MYPAC, MAP teams, A-teams, and AOP programs.

In FY 2009, the DMH Executive Director continued to serve as chair of the ICCCY, and the Director of the Division of Children and Youth Services served as chair of the ISCC. The ISCC met on October 8, 2008, to discuss the ICCCY meeting agenda, Interagency Agreement, agency updates, and an Action Plan. The ISCC met in December 2008 at a networking luncheon with the MAP Team

Coordinators. The ISCC also met on February 4, 2009 and June 24, 2009 to discuss new membership, legislation, agency updates, cross-training efforts, and to develop a plan for consultation on new/revised ICCCY legislation for 2010. The ICCCY met on October 10, 2008, and was updated on the System of Care Project, MYPAC, FASD project, Youth Suicide Prevention efforts, and family involvement. The ICCCY also met on April 24, 2009, and addressed the following topics: each agency's cash contribution for FY 2010 Interagency Agreement; discussed and made a motion to support reauthorization of MS System of Care legislation; received ISCC updates on activities; and observed a local Making A Plan (MAP) presentation.

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 strategic plan.

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

Was objective achieved? Yes

State Level Case Review/MAP Team

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 provide a social work intern 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.

Comparison/Narrative:

In FY 2008, the State Level Case Review Team reviewed ten (10) cases, of which four cases were of youth who were diagnosed sexually reactive and also were diagnosed with serious emotional disturbance. A meeting was held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

In FY 2009, the State Level Case Review Team reviewed 19 cases, of which four cases were youth who were diagnosed sexually reactive and also diagnosed with a serious emotional disturbance. A meeting was held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

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.

Was objective achieved? Yes

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

Comparison/Narrative:

In FY 2008, 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 10 targeted children/youth with SED reviewed by the team. In FY 2009, 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 19 targeted children/youth with SED reviewed by the team.

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)

Was objective achieved? Yes

Making A Plan (MAP) Teams

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.

Comparison/Narrative:

In FY 2008, the Division of Children and Youth Director coordinated six statewide meetings with the coordinators of local MAP Teams. The following items were discussed throughout the year: the local System of Care project, commUNITY cares, the Fetal Alcohol Spectrum Disorder project, the Division of Medicaid Demonstration Grant, MYPAC, case reviews, the concept mapping report and progress, MAP Team expansion, and youth suicide prevention activities. Technical assistance was provided to MAP teams in CMHC regions 5, 6, 7, 9, 12, and 13. Technical assistance regarding the expansion and development of MAP teams was provided to CMHC regions 2 and 11.

In FY 2009, the Division of Children and Youth Services Director had coordinated six statewide meetings with the coordinators of local MAP Teams. The Department of Human Services, Division of Youth Services' Adolescent "A" Team Coordinators attended one meeting held in February 2009. The following items were discussed throughout the year: the Fetal Alcohol Spectrum Disorder project, interagency meetings and trainings, ICCCY/ISCC activities, MS System of Care study and assessment, MYPAC, case reviews, MAP Team expansion, youth suicide prevention activities, and juvenile justice. Technical assistance was provided to MAP Teams in CMHC regions 2, 5, 6, 8, 9, 11, 12, 13 and 15. Technical assistance regarding the expansion of MAP Teams was provided to Region 2, 6, 9, and 11.

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

Was objective achieved? Yes

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 35 teams)

PI Data Table C3.1	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# MAP Teams with Flexible Funding	16	16		
# MAP Teams with access to flexible funding			35	37

Comparison/Narrative:

In FY 2008, one DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP teams. In addition, Region 8 received one additional MAP team to provide flexible funding for children with fetal alcohol syndrome disorder. In FY 2008, a total of 35 MAP teams continued to operate statewide and had accessibility to flexible funding through the 15 CMHCs and Catholic Charities.

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 and had accessibility to flexible funding through the 15 CMHCs and Catholic Charities.

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

Was objective achieved? Yes

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.

Comparison/Narrative:

In FY 2008, the DMH C & Y staff continued to participate in interagency committees and attended meetings with the following groups:

- Long-Range Planning Committee (Mississippi State Mental Health Planning and Advisory Council)
- Lookin' to the Future Conference Planning Committee
- Shared Youth Visions Task Force
- Alcohol and Drug Advisory Council
- Youth Summit Planning Committee
- Multicultural Task Force
- Case Management Task Force
- Youth Court Task Force
- Underage Drinking Task Force
- MS Alliance for School Health Conference Planning Committee
- MS Advisory Council on FASD
- Youth Suicide Prevention Council
- DHS State Citizen's Review Board,
- Interagency System of Care Council
- Co-Occurring Disorders Coordinating Committee
- Children's Services Task Force (of the Mississippi State Mental Health Planning and Advisory Council)
- Transition Age Task Force

In FY 2009, the DMH Children and Youth Services staff participated on the following interagency committees and attended meetings with the following groups:

- Interagency System of Care Council
- State Level Case Review Team
- Lookin To The Future Conference Planning Committee,
- Advisory Council for FASD
- Case Management Task Force
- MADCP (MS Association of Drug Court Professionals)
- Drug Court Conference Committee
- American Pediatrics Association Mental Health Task Force
- Underage Drinking Task Force
- Prevent Child Abuse Advisory Council
- Multicultural Task Force
- Youth Suicide Prevention Advisory Council
- “Cradle to Prison Pipeline” Summit Planning Committee (Children’s Defense Fund),
- Department of Human Services Citizens Review Board,
- Mississippi Alliance for School Health Conference Planning Committee
- commUNITY cares (SOC project) Core Committee, Sustainability Committee, and Cultural & Linguistic Committee.

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.

Was objective achieved? Yes

Objective: To continue to require in Request for Proposal guidelines that all private, non-profit providers receiving CMHS block grant, SSBG and/or state grant funds for children and youth services establish and operate and/or participate in a local level MAP team to address the service needs of children and youth with serious behavioral and emotional disorders who are most at-risk for being placed in a 24-hour institutional placement.

Population: Children with serious emotional disturbance

Criterion: Children’s Services

Brief Name: Participation in local MAP teams

Indicator: Assurances in grant awards by nonprofit providers receiving CMHS block grant, SSBG and/or state grant funds will document that they operate and /or participate in a local MAP team. CMHCs must meet this requirement, as monitored by DMH Division of Children/Youth Services on site visits.

Measure: Percentage of providers that comply with this requirement or submit an approved Plan of Correction to achieve compliance (for CMHCs).

Comparison/Narrative:

In FY 2008, service providers funded with CMHS Block Grant funds for children and youth continued to be required to include in their proposals for these funds, strategies that they would participate in or establish local MAP teams. Service providers funded with CMHS block grant funds continue to be monitored twice a year for compliance. All providers that receive DMH funding have participated on one or more local MAP teams (100% compliance).

In FY 2009, service providers funded with CMHS Block Grant funds for children and youth continued to be required to include in their proposals for these funds, strategies that they would participate in or establish local MAP teams. Service providers funded with CMHS block grant funds continue to be monitored twice a year for compliance. All providers that receive DMH funding have participated on one or more local MAP teams (100% compliance).

Source(s) of

Information: Division of Children and Youth Services Residential Monthly Summary forms/Grant Proposals; DMH site/certification visit reports.

Special

Issues: CMHCs providing mental health case management services for children must also participate in a local MAP team, in accordance with DMH *Minimum Standards*.

Significance: For those contractors failing to meet this requirement, i.e. accountability, certification will be revoked, i.e., all associated rights and privileges.

Funding: Local, State, and Federal funds

Was objective achieved? Yes

Health and Mental Health Initiatives and Substance Abuse Services, including work with other agencies, is described under Criterion #1.

Social Services Initiatives

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 (IDEA)

As explained in more detail in the State Plan, educational services, including special educational services under the Individuals with Disabilities Education Act (IDEA 04) continued to be available to children with serious emotional disturbances who met eligibility criteria in accordance with state and federal special education guidelines. As noted under Criterion #1, the DMH Division of Children and Youth Services and local community mental health service providers continued in FY 2007 and FY 2008 to include schools in their outreach and interagency collaboration activities. A major area of growth in the system of care has been the development through community mental health centers of school-based treatment statewide, which is also the primary strategy for increasing accessibility of services for youth in rural areas. Representatives of the MS State Department of Education are participants on state-level interagency groups described previously in this section, and local school district representatives are participants on local Making a Plan (MAP) teams. Community mental health centers also provide training on children’s mental health services to local teachers. DMH also continued to invite appropriate personnel across the system of care to selected training activities. DMH will also continue, upon request, to participate in training by other agencies, including making materials available and/or presentations about mental health services for youth.

Specific examples of educational services/assistance accessed at the local level for children with serious emotional disturbance and/or their families by individual community mental health children's services providers in FY 2009 included: general and special education services, GED programs, tutoring in reading, parenting classes, literacy training, after school tutoring, psychological testing, computer classes, mentoring, purchasing of computers and other school supplies, special education transition services, English and second language programs, college coursework, budgeting, nutrition and meal planning, problem solving and stress management, independent living skills training, college preparatory classes, educational advocacy, IDEA training, consultation on due process, information leadership training, and vocational training. These educational services/supports were provided by a variety of entities, such as local school districts, state universities, community colleges, Family Resource Centers, community mental health centers, Boys and Girls Club, private practitioners, Mississippi Department of Transportation, local churches, a local foundation, Boy Scouts, Families First, the Renaissance Program, Mississippi Department of Human Services, Headstart, vocational-technical centers, a MAP team, the Mississippi Department of Education, the Mississippi Department of Transportation, Job Corps, MIDD, Mississippi Employment Security Commission, Disability Rights Mississippi, Mississippi Families As Allies for Children's Mental Health, Inc., MS Parent Training and Information Center, Mississippi Youth Justice Project, Good Shepherd Community Center and the Youth Challenge Program.

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" (105 in 2008) 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 CMHC's 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 Target	FY 2009 Actual
Performance Indicator				
% age of Families of children/adolescents reporting improvement in child's school attendance	54.2%	44.3%	48%	41%
Numerator: Number of families of children/adolescents reporting improvement in child's school attendance (both new and continuing clients)	89	78	95	158
Denominator: Total number (including Not Available) (new and continuing clients combined)	164	176	196	385

Was objective achieved? The action plan was implemented; however, the percentage reporting improvement in school attendance decreased. The factors leading to this decrease are not known, but it should be noted that the number of overall responses to this item on the survey increased, as was anticipated, since the sample size was increased from 10% to 20%.

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.

DMH Division of Children and Youth Services staff has been working with the Department of Human Services, Division of Youth Services to implement a substance abuse treatment curriculum in the training schools and in the Adolescent Offender Programs. DMH will continue to encourage and support continuation of existing programs, as well as expansion of the programs to other regions of the state in FY 2009. In FY 2009, the DMH Division of Children and Youth Services staff continued to monitor, certify and provide technical assistance to community mental health centers (Regions 3,4,6,7,10,11,12 and 15) and one nonprofit program operated in Hinds county and one operated by Catholic Charities in Adams county.

National Outcome Measure (NOM): Decreased Juvenile Justice Involvement

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 (12 in 2008) 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. AOPs 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 Target	FY 2009 Actual
Performance Indicator				
% age of children/adolescents Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	57	33	46	50
Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	8	4	6	14
Denominator: Total number of children/adolescents arrested in T1 (new and continuing	14	12	13	28

clients combined)				
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Was objective achieved? Yes

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

Transitional Services Task Force

Objective: To continue development of strategies for enhancing and/or increasing appropriate service options for transitional age youth (14-24).

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Transitional services planning

Indicator: Participation by designated Division of Children and Youth Services staff, who will chair the Transitional Services Task Force, in coordination with the Division of Community Services.

Measure: Percentage of meetings held annually in which designated Division of Children and Youth participates and co-chairs the Transitional Services Task Force with the Division of Community Services.

Comparison/Narrative:

In FY 2008, the Transitional Services Task Force, formed to better identify and plan to assess needs of youth, age 16 to 25 years, continued its interagency initiatives. The task force met on November 29 2007, and May 20, 2008, 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, which was identified as an age at which children/youth begin to fall out of the system. Through learning about the Transitional-Outreach Program (TOP), 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. The task force includes representatives from a local mental health center that provides a transitional living program, as well as representatives from the Mississippi 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. . A task force meeting held in November 2007 focused on discussion of availability and accessibility of appropriate services for the targeted age group. The Chairperson of the Transitional Services Task Force met with members individually to discuss progress on goals in the previous year and to reassess priorities. The Chairperson met with the Division of Medicaid representatives to discuss reimbursable services for the transitional age group and has monitored outreach programs, tracking the number of youth served in transition age programs and reviewing outcome measures. Goals of the task force at mid-year included: maximizing available financial resources for services for the transitional age group; dissemination of information and creation of a special website; and, development of more structured programming. A task force meeting held in May, 2008 focused on the steps taken to create a special website; funds were not yet available for development of a special website or resource directory during this time period. The development of new residential programs was discussed for youth in foster care in the transitional age range. Additionally, transitional-age youth are included as a target population addressed by the ICCCY and to be served by MAP teams. Also, the Transition Services Coordinator for the MS Department of Rehabilitation Services has continued to serve on the State-level Case Review Team. Task Force members also planned to attend the Transitional Youth Conference, cosponsored by the Department of Rehabilitation Services and the Department of Education in October 2008. In FY 2009, the transitional task force met on November 2008 and May 2009, to develop strategies related to increasing appropriate service options.

Source(s) of

Information: Minutes of meetings of the workgroup; Monthly staffing forms.

Special

Issues: The Transitional Age Task Force now focuses on children/youth ages 14-24.

Significance: The Transitional Age Task Force focuses on services being provided to transitional age youth, age 14-24. By identifying barriers and making recommendations specific to these needs, this age group will be better identified and served through the CMHCs and other parts of the service system.

Funding: Federal and state

Was objective achieved? Yes

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

Transitional Living Programs

Objective: To continue funding for mental health services for youth in two transitional therapeutic group home 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 home 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 services (four)

PI Data Table C3.5	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# Transitional Living Homes/ Supported Living Programs Funded	2	2	4 transitional living programs	4 transitional living programs received DMH funding; 2 additional programs were certified, but not funded by DMH

Comparison/Narrative:

In FY 2008, two therapeutic group homes, Rowland and Harden House, served 40 youth. In FY 2009, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and Hope Village (two programs); 4 of the homes received DMH funding support.

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

Was objective achieved? Yes

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

Goal: To continue support for an existing program for runaway/homeless youth and youth who are homeless/potentially homeless due to domestic violence.

Objective: To continue DMH funding for partial support of an outreach coordinator in an existing program serving runaway/homeless youth.

Population: Children with Serious Emotional Disturbance

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Outreach to homeless/runaway youth

Indicator: Continued funding at the same level as in the previous year.

Measure: The number of homeless/runaway youth served through this specialized program (90).

PI Data Table C4.1	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# Homeless/ Runaway Youth with SED Served	177	163	90	43

Comparison/Narrative: In FY 2008, the DMH continued to provide at the 50% level of funding for the SAFE Place Coordinator's salary. Our House Emergency Shelter reported having contact with 163 youth in FY 2008.

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. As of March 2009, the DMH continued to provide at the 50% level of funding for the SAFE Place coordinator salary. Adult volunteers who are trained in crisis intervention offered assistance and transportation to the shelter for youth who could not return home.

Source(s) of Information: Program grant

Significance: Provision of partial funding for the Outreach Coordinator at Our House facilitates outreach and identification of youth in need of comprehensive services because of their homelessness, including youth with serious emotional disturbances.

Funding: Federal

Was objective achieved? The targeted number of children (90) was not reached because the Our House shelter was closed March 31, 2009. Our House Residential Program has transitioned from a residential-based program to the community Host Homes model, which is under the therapeutic foster care umbrella of Catholic Charities, Inc. (program operator). Youth being served the last weeks of the program returned to their home.

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 (75).

PI Data Table C4.2	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# Children with SED in Domestic Violence Situation Served	8	74	75	71 children served; 60 with SED

Comparison/Narrative:

In FY 2008, Gulf Coast Women's Center reported serving 115 youth, 74 of whom were children with SED. According to anecdotal report by the provider, individuals served in FY 2008 exhibited more complex traumas and problems (with some not yet back in their homes). In FY 2009, Gulf Coast Women Center served 71 youth, 60 of whom were children with SED or at risk for emotional illness. These children are served in an emergency homeless shelter setting that is specific to domestic violence.

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

Was objective achieved? Yes

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 (100).

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

Comparison/Narrative:

In FY 2008, funding continued to be provided to Region 13 Gulf Coast Mental Health Center to support services to a local shelter for abused/neglected children. The shelter provided services to 353 children in FY 2008; all children were enrolled in the services at Region 13 and had a serious emotional disturbance.

In FY 2009, funding continued to be provided to Region 13 Gulf Coast Mental Health Center to support services to a local shelter for abused/neglected children. The shelter provided services to 294 children in FY 2009; all children were enrolled in the services at Region 13 and had a serious emotional disturbance.

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 of 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

Was objective achieved? Yes

Coordination with Other 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.

Comparison/Narrative:

In FY 2008, all therapeutic group home providers, including Our House Shelter, participated in a two-day intensive workshop provided by a consultant on *Managing Aggressive Behaviors in Youth with SED*. This training also included a one-day on-site technical assistance visit by the consultant and DMH Division of Children and Youth Services staff. Providers of services to runaway/homeless youth also had the opportunity to receive training at the annual *Lookin' to the Future* conference.

In FY 2009, all therapeutic group home providers, including Our House shelter, continued to receive technical assistance on managing aggressive behaviors in youth with SED. Providers of services to runaway or homeless youth will also have the opportunity to receive training at the annual Lookin' to the Future Conference.

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

Was objective achieved? Yes

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

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 (Target)	FY 2009 (Actual)
# Providers Receiving T.A. /certification visits	15	15	10	15

Comparison/Narrative:

In FY 2008, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to all 15 CMHC regions. In FY 2009, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to all 15 CMHC regions.

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

Was objective achieved? Yes

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 2009, 13 CMHCs and seven other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; nine CMHCs and reported making transportation available through affiliation agreement with other agencies; and, nine CMHCs and three other nonprofit programs reported utilizing local public transportation (buses, cabs, Medicaid transportation etc.).

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 2009).**

Efforts to Increase Funding

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 2010 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 2010 DMH Budget Request.

Comparison/Narrative:

During the 2009 Legislative session, DMH requested the following increases in General State funds for Fiscal Year 2009 for community mental health services for children: for deficit in Medicaid match on payments made to the regional community mental health centers - \$9,900,000; first year funding of services in the Mississippi Access to Care (MAC) Plan - \$3,408,800. No additional funding was

appropriated for the fiscal year that ends June 30, 2009. However, DMH did receive an additional \$10 million in General funds for the year that ended June 30, 2008, for match on Medicaid payments made to the regional community mental health centers, reducing by almost half the amount that was assessed to the CMHCs to fund the deficit.

Because of the significant financial problems facing the State of Mississippi during the 2009 Legislative Session, the Department of Mental Health limited its requested increase in State General funding to \$24,000,000 to fund the Medicaid match deficit for Medicaid receipts at the 15 regional community mental health centers, and \$1,006,678 to replace an anticipated cut of a like amount in federal Social Services Block Grant (SSBG) funding.

Prior to the “stimulus plan” (American Recovery and Reinvestment Act, or ARRA), Mississippi’s 15 CMHCs were projected to receive approximately \$141 million in Medicaid receipts during the fiscal year that began July 1, 2009. The state share of that was estimated to be \$34 million, and this is the amount that the Division of Medicaid was expected to bill DMH for match. Only \$10 million was expected to be available, though, so DMH asked for an increase of \$24 million to fully fund it. Absent that increase (or some part of it), the 15 mental health centers would, collectively, have been assessed to come up with the \$24 million using a formula that was based primarily on their actual Medicaid receipts (as has been the practice for the last approximately seven years).

Because of ARRA, Mississippi’s share of Medicaid match was reduced from 24.16% to 15.76%. This meant that the state share of \$141 million in Medicaid receipts would be reduced from about \$34 million to about \$22 million, a savings of \$12 million. Under the mistaken belief that the entire match need of \$34 million had been funded, the legislature “swept” \$12 million from DMH’s appropriation. Unfortunately, only \$10 million had been funded, which means that all of the appropriated funds for match were “swept” plus an additional \$2 million. Although DMH has been advising the legislature for years that the match was not fully funded, because of the intensity of the last days of the 2009 session, that simply got overlooked and by the time DMH knew this “sweep” had occurred, it was too late to fix it. (DMH did not have an appropriation until the 2nd Extraordinary Session, and the bill that was finally passed was signed by the Governor at 11:51 p.m. on June 30, 2009, the day before the new fiscal year began. DMH did not receive the bill or know the final results until mid-July).

Governor Barbour and key legislators have been made aware of this result and have pledged to do anything that can be done that is also fiscally responsible to address it during the 2010 legislative session. In the meantime, DMH has transferred about \$10 million of funds appropriated to other needs to be used for this Medicaid match. The remaining shortage of \$12 million will be assessed to the mental health centers. Approximate 45% of Medicaid match is for children and youth, and approximately 55% is for adults. In summary, no additional

funding was received for Medicaid match and, a 100% cut was received. The anticipated cut to SSBG funding did not occur.

Source(s) of

Information: DMH Budget Request, FY 2010

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

Was objective achieved? Yes

Mental Health Transformation Activities: Workforce Development

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

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.

Comparison/Narrative:

In FY 2008, the Division of Children and Youth Services continued to maintain a training calendar, which includes training provided, facilitated or attended by the Division of Children and Youth Services in FY 2008, as follows:

October 2007: Provided children's mental health information to Adolescent Offender Program providers, Minimum Standards training for CMHT-Module III, and interagency collaboration at the Social Work Conference in Tupelo.

November 2007: Provided Case Management Module II training,

December 2007: Provided *Applied Suicide Intervention Skills Training (A.S.I.S.T.)*

January 2008: Provided and sponsored intensive training on *Managing Aggressive Behaviors in Youth* for therapeutic group home providers across the state.

February 2008: Provided youth suicide prevention information to alcohol and drug prevention specialists and local university students and FASD Basics to staff at DREAM, Inc.

March 2008: Provided training on MAP Teams and Community Mental Health for Division of Medicaid MYPAC providers, youth suicide prevention training to staff at East MS State Hospital, Case Management Orientation and Case Management Module II training.

April 2008: Provided *Applied Suicide Intervention Skills Training (A.S.I.S.T.)* to mental health professionals and Preventing FASD in MS at the Oklahoma Joint Conference on FASD and Underage Drinking.

May 2008: Provided cultural competency training to the Mental Health Association of Mississippi, FASD Basics training to MAP Team members and staff at Hudspeth Center, Case Management Module II training, Minimum Standards training for CMHT-Module III, and intensive training on *Managing Aggressive Behaviors in Youth* for therapeutic group home providers in Central MS.

July 2008: Provided FASD Orientation to children's coordinators and MAP Team coordinators and training on mental health issues in juveniles at the Juvenile Justice Symposium.

August 2008: Provided Minimum Standards training for CMHT-Module III, Youth Suicide Prevention training to Catholic Charities volunteers and Youth Suicide Prevention activities at the First Annual Youth Suicide Prevention Workshop.

September 2008: Provided FASD Project updates at the *5th Annual FASD Symposium*, Suicide Prevention on College Campuses to Jackson State University students, Children's Mental Health Updates for the Coalition on Child Welfare, Mental Health in Juveniles at the Annual Youth Defenders Workshop, and System of Care training at the annual MS Alliance for School Health (MASH) Conference.

In FY 2009, Division of Children and Youth staff provided and/or facilitated the following training for providers of mental health services for children/youth:

October 2008: Provided FASD 101, FASD screening and referral training; Updates on mental health certification at the Annual Adolescent Offender Programs training.

November 2008: Provided an overview of children's mental health services at the University of Southern Mississippi Social Work Fall Colloquium and cultural competency and diversity training at the Annual Mental Health/Mental Retardation Conference.

December 2008: Provided training on Managing Aggressive Behaviors in youth for therapeutic group home and foster care providers; provided MAP Team 101 for new coordinators.

January 2009: Assisted in facilitating sessions on youth with alcohol and drug abuse at the 2nd Annual MS School of Addiction Professionals; provided FASD training for the MS Healthcare Association.

February 2009: Assisted in facilitating the Annual KIDS COUNT Summit; provided updates on children's mental health services at the MS Vocational Rehabilitation Conference.

April 2009: Coordinated a Cultural Competency Workshop; assisted in coordinating the MS Gulf Coast Youth Suicide Prevention Conference; participated in the Child Abuse Awareness Press Conference.

May 2009: Provided an update on children's mental health at the Central MS Social Work Conference; provided cultural diversity training at the Annual Consumer Conference; coordinated the Children's Mental Health Awareness Press Conference; provided an overview of Mississippi's mental health system at the Mental Health Summit on the Gulf coast; and assisted in coordinating the Youth Drug Court Conference.

June 2009: Provided youth suicide prevention training at the Annual School Safety Officer training.

July 2009: Provided FASD 101 and FASD updates at the Annual Lookin to the Future Conference; provided an update on MAP Teams at the Annual Lookin to the Future Conference.

September 2009: Coordinated the annual FASD Symposium; assisted with coordinating the NCAAD (spell out name) and MAAP (spell out name) Conferences; provided updates on children's mental health services at the Annual MS Alliance for School Health Conference; coordinated the Youth Suicide Prevention Workshop; provided an update on children's mental health services at the Youth Court Judges & Referees Seminar; and, provided an update of MAP

Teams at the annual MS Youth Programs Around the Clock (MYPAC) training.

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

Was objective achieved? Yes

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 (Target)	FY 2009 (Actual)
# Attendance at Statewide Institute or DMH-sponsored conference	796	885		

# of statewide conferences and/or training sessions sponsored or co-sponsored by DMH CYS			Four	Four
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Comparison/Narrative:

In FY 2008, the DMH Division of Children and Youth Services served as the premier sponsor of the 20th Annual *Lookin' to the Future* conference and *The Mississippi Permanency Partnership Network Conference* conducted by Southern Christian Services for Children and Youth, which was held July 16-18, 2008. The conference theme was "Don't Stop Thinking about Tomorrow" and included 52 workshops on topics such as Childhood Trauma & Assessment, Teen Suicide Awareness & Prevention, Alcohol & Drug Abuse in youth, STDs/HIV, Fetal Alcohol Spectrum Disorders, Supervision & Leadership, Parenting Practices for foster care, Psychiatric Medications for youth, Evidenced-Based Practices, Family Therapy, Independent Living, Psychological Evaluations, Autism, ADHD & Learning Disorders, Domestic Violence, and Supervised Visitations. Professional development was provided for mental health therapists, case managers, marriage and family therapists, alcohol and drug counselors, rehabilitation therapists, recreational therapists, social workers, and psychologists. This conference was attended by 885 individuals.

In FY 2009, the DMH Division of Children and Youth sponsored the First Annual Gulf Coast Suicide Prevention Conference in April 2009. DMH also sponsored a Cultural and Linguistic Training in April 2009 for all providers. In July 2009, DMH continued to serve as a primary sponsor of the 21st Annual *Lookin' to the Future* and *The Miss. Permanency Partnership Network Conference* conducted by Southern Christian Services. DMH also continued to sponsor the annual Mississippi Alliance for School Health Conference held in September 2009, with a pre-conference focused on Youth Suicide Prevention.

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

Was objective achieved? Yes

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

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.

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

Comparison/Narrative:

In FY 2008, the Mississippi Trauma Recovery for Youth (TRY) Project completed three Learning Collaboratives. Each Collaborative involves supervisory staff, three, two-day Learning Sessions and monthly phone consultations at intervals over a 12-month period. The Learning Sessions were held on November 5-6, 12-13, 2007; December 10-11, 2007; and April 23-24, and May 5-6, 2008. There were 83 participants in the Learning Collaboratives.

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 was

attended by 78 therapists and clinicians and resulted in 121 children/youth receiving TF-CBT. Each Collaborative involves supervisory staff in three, two-day Learning Sessions and monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT.

Source(s) of

Information: Division of Children and Youth Services monthly grant report forms

Special

Issues: Priority for expansion of training will be in those counties on or just north of the Gulf Coast.

Significance: Expansion of training in this area will address needs to enhance skills of community mental health services staff in providing trauma-informed care, while also providing additional information on use of the learning collaborative model to implement evidence-based practices.

Funding: CMHS Block Grant, local funds

Was objective achieved? Yes

Case Manager Training

Objective: To continue staff development activities for children’s mental health case managers.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Case management training provided

Indicator: Provision of a two-day orientation/continuing education training session on case management.

Measure: The number of times per year that case management training is offered (eight).

PI Data Table C5.3	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
# Case Management Training Sessions	8	8	8	7

Comparison/Narrative:

In FY 2008, the Department of Mental Health has continued to make available case management orientation training for staff hired as case managers in the public community mental health system. In FY 2008, DMH held eight case management orientation sessions (in October 2007; February, March, April, May, and July, 2008, and two sessions in September 2008). A total of 258 case managers completed case management orientation (Module I) in FY 2008.

In FY 2009, In FY 2009, DMH held seven case management orientation sessions (in October 2008; February, March, April, May, and July, 2008, and one session in September 2009). A total of 180 case managers completed case management orientation (Module I) in FY 2009.

Source(s) of

Information: Division of Children and Youth Services staffing report forms

Special

Issues: The measure of this objective was changed to be more quantitative. Additional training for children/youth case managers is available upon request and documented monthly on the Division report forms.

Significance: Case managers are required by DMH Minimum Standards to receive training at least annually.

Funding: Local, state, and federal funds

Was objective achieved? No, seven training sessions were held instead of the eight targeted. Eight training sessions were scheduled; however, only one of two training sessions scheduled for September was held because only one session had enough participants registered to justify holding the training.

Mental Health Transformation: Workforce Development

Mental Health Therapist Certification and Licensure Program

Mental Health Administrator Licensure Program

Case Manager Certification Program

Objective: To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Mental Health Administrator licensure program and the Case Management Certification 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 Mental Health Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE).

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 Mental Health Administrator program; the number of individuals who hold a credential in the Case Management Certification program.

Comparison/Narrative:

In FY 2008, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 432 booklets were distributed. By the end of FY 2008 (September 30, 2008), a total of 1,959 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Provision of the Mental Health Core Training Program (MH-CTP) continued throughout FY 2008. The MH-CTP is comprised of three separate, week-long modules (Module I, Module II and Module III) each of which concludes with a written examination. In FY 2008, Module I was offered in January, April and July 2008. Module II was offered in March and September 2008. Module III was offered in October 2007 and again in May and August 2008.

In FY 2008, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 22 booklets were distributed. By the end of FY 2008 (September 30, 2008), the Licensed Mental Health Administrator program included a total of 122 individuals; 31 Program Participants and 91 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the six required written examinations. As of the most recent renewal deadline, December 31, 2007, approximately 70 renewing licensees reported having received 2,800 Contact Hours.

In FY 2008, PLACE staff continued to offer all six written exams for the Licensed Mental Health Administrator program in final form. Written examinations were made available to Participants one day each month. A total of 45 written

examinations were administered to Participants in FY 2008.

In FY 2008, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; approximately 119 booklets were distributed. By the end of FY 2008 (September 30, 2008), a total of 629 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Provision of the Case Management Core Training Program (CM-CTP) continued throughout FY 2008. The CM-CTP is comprised of three separate training sessions (Module I, Module II and Module III) each of which concludes with a written examination. In FY 2007, Module I was made available in October 2006 and in February, March, April, May, July and September 2007. Module II was offered in October, November, January, February, March, April and May 2007 while Module III was available on a quarterly basis. In FY 2008, Module I was made available in October 2007 and in February, March, April, May, July and September 2008. Module II was offered in November 2007 and March, May and September 2008. Module III continued to be made available on a quarterly basis.

In FY 2009, a change was made to the application process for individuals applying to move up (upgrade) from provisional certification to full certification that affected both the Mental Health Therapist Program and the Case Management Certification Program. It was decided that applicants would no longer be required to report continuing education hours at both the time of upgrade and the time of renewal. This was determined to be an unnecessary duplication of effort. Rather, we would continue to require continuing education to be addressed at the time of renewal.

In FY 2009, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 125 booklets were distributed. By the end of FY 2009, a total of 2,161 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Also in FY 2009, changes were made to the Mental Health Core Training Program (MH-CTP). The MH-CTP requirement was streamlined from three separate, week-long modules and written examinations to one written Mental Health Therapist examination with self-study as the basic format for test preparation. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009. The content of the remaining one written exam continues to be material outlined by a steering committee made up of community mental health service providers, consumer advocates, consumers/family members,

administrators, etc. During FY 2009, the required Mental Health Therapist exam was administered to 146 individuals.

In FY 2009, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 15 booklets were distributed. By the end of FY 2009, the Licensed Mental Health Administrator program included a total of 126 individuals; 25 Program Participants and 101 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the required written examinations or his/her participation in DMH's leadership development program called Focus. As of the most recent renewal deadline, December 31, 2007, 68 renewing licensees reported having received the required 40 Contact Hours. The next renewal deadline will be December 31, 2009.

In FY 2009, PLACE staff continued to offer written exams for the Licensed Mental Health Administrator program. Written examinations were made available to Participants at least one day each month. A total of 2 written examinations were administered to Participants in FY 2009.

In FY 2009, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; 26 booklets were distributed. By the end of FY 2009, a total of 758 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Also in FY 2009, changes were made to the Case Management Core Training Program (CM-CTP). The CM-CTP requirement was streamlined from three separate modules and written examinations to one required training (Case Management Orientation) and written examination. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009.

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

Was objective achieved? Yes

The number of individuals who hold a credential in the Mental Health Therapist program, the number of Program Participants in the Mental Health Administrator program, and, the number of individuals who hold a credential in the Case Manager Certification Program in FY 2007 - FY 2008 and projected and actual numbers for FY 2009 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
Mental Health Therapists (all levels)	1,733	1959	1,973	2,161
Mental Health Administrators (all levels)	121	122	122	126
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	607	758

Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in FY 2009, with 14 CMHCs and six 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: community counseling, social work, psychology, counseling, education, educational psychology, community counseling, school counseling, human services, sociology/criminal justice, family and human development, counselor education, nurse practitioners, nursing, public health, marriage and family counseling, industrial counseling, and nursing psychology.

Information Management Systems Development

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 Data Infrastructure Grants, including the FY 2008-2010 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 FY 2008-2010 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.

Comparison/Narrative:

In FY 2008, DMH continued working closely with the ITS consultant and service providers on the development of the central data repository. DMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

As the process moves forward, aggregate data is still being collected. However, we are now starting to compare the aggregate data to the data compiled by the CDR.

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

There continues to be ongoing communication between DMH and the CMHC common data systems users group. This group meets six times yearly to discuss issues related to data collection, data reporting, and billing. DMH staff are invited members of the group and use it as a

forum to discuss any data issues as well as state planning related matters. The ITS consultant working on development of the central data repository also attended these meetings. The meeting is open to all 15 CMHC regions. Minutes of the meetings are distributed to representatives of all CMHC regions.

In FY 2009, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Thirteen out of 15, or 87%, of regional community mental health centers (CMHCs) and two out of four, or 50%, of the state psychiatric hospitals are presently submitting data that populates the database.

The Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are about to embark on the task of setting up the Children's non-profits so they may enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables but we hope to have that task completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

Our continued approach has been to address collection, software upgrades, reporting quality, and training issues pertaining to the data at the local level, to bring all data from administrative sources into the central data repository by file upload and browser based data entry, to provide for monitoring of the data for accuracy and timeliness by Central Office personnel and to report the data to the CMHS in the form of the URS tables and in the State Plan as National Outcome Measures as required.

Ongoing technical assistance and training is also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training is also planned to facilitate communication among stakeholders.

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

Was objective achieved? Yes

**(Amended) Projected Expenditures of Center for Mental Health Services Block Grant
For Children's Community Mental Health Services
by Type of Services for FY 2009**

<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

**(Amended) Projected FY 2009 CMHS Block Grant Projected Allocation of 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 Michael Roberts, Ph.D., 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 Interim 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

Mississippi

Southern Christian Services for Children and Youth 120,000
1900 North West St., Suite B
Jackson, MS 39202
Sue Cherney, Executive Director
(Mental Health Services for Transitional TGHs and Training)

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

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 17,424
and training, which may be granted to local 5,000
entities for implementation)

TOTAL \$1,549,296

Note: A total of \$187,179 (5% of the total amended award to be spent on services in FY 2010) 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.

b) **FY 2009 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.**

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

Quality Improvement System Development

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

Peer Review

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: Inclusion of peer monitors for adult community mental health in conjunction with selected site/certification visits to community mental health centers, and technical assistance provided at each site visit additionally, upon request.

Measure: Percentage of site/certification visits that will also include a peer monitoring visit. (At least 50% of community mental health center provider site/certification visits.)

Comparison/Narrative:

In FY 2008, the Department of Mental Health's newly established Division of Consumer and Family Affairs assumed responsibility for peer reviews for the Division of

Community Services for Adults and the Division of Children and Youth Services. The new Division conducted a survey of the 15 community mental health centers, community programs operated by two state hospitals, peer reviewers and other interested stakeholders regarding the effectiveness of the peer review process. The Division suspended all peer reviews temporarily while it is implementing efforts to address concerns indicated by survey results. As of April 2008, peer reviewers for adult community mental health services had visited five community mental health centers and involved 13 peer reviewers. Of the 13 reviewers, six were individuals receiving services, two were family members and five were professionals. Once improvements to the peer review process were implemented, peer review visits were resumed.

In FY 2009 peer reviewers for adult community mental health services had visited 10 community mental health centers and involved 20 peer reviewers. Of the 16 reviewers, 13 were individuals receiving services, 3 were family members and 4 were professionals.

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.

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.

Funding: CMHS Block Grant Funds

Was objective achieved? Yes

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 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 has been 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 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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
% Reporting Positively about Outcomes	73%	71%	73%	74%
Numerator	491 positive responses	447 positive responses	491 positive responses	1071
Denominator	690 responses	628 responses	690 responses	1453

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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
1. % Reporting Positively about Access	87%	89%	87%	89%
Numerator	593 positive responses	564 positive responses	593 positive responses	1332 positive responses
Denominator	679 responses	636 responses	679 responses	1494 responses
2. % Reporting Positively about Quality and Appropriateness for Adults	88%	90%	88%	91%
Numerator	599 positive responses	569 positive responses	599 positive responses	1351 positive responses
Denominator	679 responses	635 responses	679 responses	1491 responses
3. % Reporting Positively about Outcomes	73%	71%	73%	74%

Numerator	491 positive responses	447 positive responses	491 positive responses	1071 positive responses
Denominator	690 responses	628 responses	690 responses	1453 responses
4. % Reporting on Participation in Treatment Planning	74%	76%	74%	80%
Numerator	480 positive responses	480 positive responses	480 positive responses	1158 positive responses
Denominator	657 responses	631 responses	657 responses	1451 responses
5. % Reporting Positively about General Satisfaction with Services	90%	90%	88%	91%
Numerator	603 positive responses	574 positive responses	471 positive responses	1366 positive responses
Denominator	673 responses	637 responses	534 responses	1493 responses

Was objective achieved? Yes

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

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).

Comparison/Narrative:

In FY 2008, OCS continued to meet bi-annually (change approved by the Board of Mental Health) with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues brought to DMH's attention concerning mental health services. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly to DMH Central Office staff and the OCS Advisory Council, including four (4) quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk" program to all DMH facilities and community mental health centers (CMHCs), as well as DMH Central Office staff. This directory gives service providers access to basic program/service information for over 2300 programs in FY 2008 and to support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. In FY 2008, 285 new programs were added and over 800 individual programs' information was updated in the reporting period. This process is ongoing.

In FY 2009, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk". This directory gives service providers access to basic program/ service information for over 2100 programs and support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. Approximately 215 new programs were added and over 600 individual program's information was updated in the reporting period. This process is ongoing. OCS recently contracted with the National Suicide Prevention Lifeline to serve as a network provider. Calls from all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since beginning to take calls in mid December 2008, OCS has received over 2300 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly 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

Was objective achieved? Yes

Mental Health Services

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

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 Department of Mental Health 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 FY 2009 DMH sponsored a four-day Peer Specialist training at Eagle Ridge Conference Center. Fourteen consumers of mental health services participated in the training. In June 2009, twelve peer specialists selected to take the Certified Peer Specialist exam; nine passed the examination.

Mental Health Transformation Activities: Support for Culturally Competent Services (NFC Goal 3.1)

Multicultural Task Force

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 2009 (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.

Comparison/Narrative: In FY 2008, the Multicultural Task Force met seven times (November 16 and December 7, 2007, and February 15, March 21, April 18, June 20, and August 15, 2008). A Peer Specialist from the DMH and a Public Relation Director from Central Mississippi Residential Facility joined as new members. The task force organized the statewide Day of Diversity held on October 12, 2007; a staff member was a guest on WLBT (a local television station) on October 9, 2007 to discuss the event. On October 16, 2007, a staff member conducted a cultural competency presentation at the Department of Health's Regional Health Disparity Summit I at Alcorn State University. The task force provided its annual report to the Mississippi State Mental Health Planning Council on August 14, 2008.

In FY 2009, the Multicultural Task Force (MCTF) met on November 21, 2008, June 22, 2009, August 17, 2009, September 14, 2009. The task force organized the statewide Day of Diversity held on October 13, 2008; on November 3, 2008, the co-chair of the MCTF presented at the 27th Annual MH/MR Joint Conference on cultural competency and disparities. On April 17, 2009, the "Cultural and Linguistic Competency: Keeping It Real" workshop was held. The presenter was Dr. Vivian Jackson with the National Center for Cultural Competency. Approximately, 85 service providers attended the workshop. The annual report of task force activities was made to the Mississippi State Mental Health Planning and Advisory Council on August 17, 2009.

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

Was objective achieved? Yes

Local Provider Cultural Competence Assessment

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.

Comparison/Narrative:

In FY 2008, Region 11 staff completed the cultural competency assessment on May 16, 2008. The region has not received the results due to technical issues in generating the report document. In FY 2009, Region 11 CMHC received their cultural competence assessment results on May 8, 2009. Staff member met with staff from Region 2 CMHC on July 21, 2009, to discuss the cultural competency assessments. Staff has not yet received a date to conduct the assessment from the Region 1 CMHC clinical director.

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

Was objective achieved? Yes

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 community mental health services staff. (Minimum of 4)

PI Data Table A1.4	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# of NCBI Training Sessions for CMHC Staff	5	4	4	6

Comparison/Narrative:

In FY 2008, 4 trainings have been conducted on November 1, 2007; December 7, 2007; April 18, 2008; and May 6, 2008. On October 16, 2007, a staff member conducted a cultural competency presentation at the Department of Health's Regional Health Disparity Summit I. On December 7, 2007, a staff member conducted a presentation on cultural competency and NCBI to a faith-based organization.

The Multicultural Task Force continued to meet in FY 2009 to identify priority areas to be addressed related to cultural issues in community mental health service delivery. The DMH continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model. Three NCBI trainings were conducted at Region 8 (Copiah County, Rankin County and Simpson County) in April 2009. An NCBI training was provided to Region 3 Mental Health Center staff in April 2009. In May 2009, staff conducted a cultural diversity training session at the Consumer Conference. NCBI training was also conducted for MS Families As Allies for Children's Mental Health, Inc. in June 2009. A NCBI training was conducted at Region 1 Mental Health Center in September 2009.

The *DMH Minimum Standards for Community Mental Health/Mental Retardation Services* continued 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 continued to require additional assurances from providers with which it contracts that training addressing cultural diversity and/or sensitivity will be provided.

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

Was objective achieved? Yes

Outpatient Mental Health Services

In FY 2008 and FY 2009, all 15 community mental health centers continued to make available general outpatient services (individual, group and family therapy). In FY 2008, the CMHCs reported that 36,979 adults with mental illness received general outpatient services. In FY 2009, the CMHCs reported that 40,282 adults with mental illness received general outpatient services.

Mental Health Transformation Activities: Improving Consumer Access to Employment Services and Supports

Rehabilitation, Employment and Educational Services

Availability of Psychosocial Rehabilitation Programs

Goal: To provide rehabilitation services for adults with serious mental illness.

Objective: Psychosocial rehabilitation clubhouse services will be provided in each CMHC region of the state.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of clubhouse psychosocial rehabilitation programs

Indicator: Availability of clubhouse programs statewide.

Measure: The number of clubhouse programs available across the state. (Minimum: 16, that is, one in each CMHC region and through one state hospital community program.)

PI Data Table A1.7	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Availability of Psychosocial Rehabilitation Programs	16 Programs; 61 sites statewide served 4574 individuals	16 Programs	16 Programs	16 Programs; 60 sites statewide served 5087 individuals.

Comparison/Narrative:

In FY 2008, there were 16 psychosocial rehabilitation/clubhouse programs in the state, one in each of the 15 community mental health regions and one operated by the Mississippi State Hospital Community Services Division (in Jackson), with 60 clubhouse sites operational statewide, and 4822 individuals were served.

In FY 2009, there were 16 psychosocial rehabilitation/clubhouse programs in the state, one in each of the 15 community mental health regions and one operated by the Mississippi State Hospital Community Services Division (in Jackson), with 60 clubhouse sites operational statewide, and 5087 individuals were served.

Source(s) of

Information: Adult Services Annual State Plan Survey

Special

Issues: The targeted number of programs per region (and through one hospital-operated community services division) is 16; however, each region has numerous clubhouse sites throughout the geographical areas they serve.

Significance: The Psychosocial Rehabilitation/Clubhouse program allows for the maximum amount of support and growth for consumers who receive the service. Through its design, members interact with peers as well as with counselors, which as research has shown, leads to greater levels of motivation for independence. The DMH and CMHCs recognize the success of the clubhouse program in maintaining or increasing the level of independence of individuals and therefore, promotes the implementation and growth of this program in Mississippi.

Funding: Medicaid, state, CMHS block grant, local funds

Was objective achieved? Yes

Drop-In Center

Objective: To make available funding to support two drop-in centers 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 two drop-in centers.

Measure: The number, age, and gender of individuals served by the drop-in centers will be tracked (baseline).

Comparison/Narrative:

In FY 2008, the drop-in center in Corinth provided services to 10 adults with serious mental illness. Half of the individuals were women and half were men; nine were 41 to 60 years of age, and one was in the age range of 61 years or above. The drop-in center in Gulfport, operated by the Mental Health Association of Mississippi provided services to 1,476 adults with serious mental illness; this total represents a duplicated count and also includes individuals who were served in BRIDGES support groups and through the program for homeless persons. Individuals served included 720 females, 714 males; gender was not available for 42 individuals. Of the individuals served, 420 were age 56 or older, 232 were in the 50-55 year age range, 608 were in the 35-49 year age range, and 216 were in the 16-34 year age range.

In FY 2009, Resource Center provided services to 26 adults with serious mental illness; 14 were women and 12 were men, five were under 41 years of age, 16 were 41 to 60 years of age, and five were in the age range of 61 years or above. The drop-in center in Gulfport, operated by the Mental Health Association of Mississippi, provided services to 183 adults with serious mental illness; this total represents a unduplicated count and also includes individuals who were served in BRIDGES support groups and through the program for homeless persons. Individuals served included 79 females and 104 males. Of the individuals served, 64 were age 56 or older, 32 were in the 50-55 year age range, 22 were in the 35-49 year age range, and 64 were in the 16-34 year age range.

Source(s) of

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

Special

Issue(s): Data collected once the program funding is increased will serve as a baseline for at least the next 12 to 18 months, during which time the drop-in center in Gulfport has expanded its operation from three days to four days per week. Once established, the drop-in center in Region 4 (Corinth) will expand operation to five days per week.

Significance: The drop-in centers, in addition to providing services to individuals with serious mental illness in the more densely populated Gulf Coast area, will also provide technical assistance to programs with existing or new day support services. Once established, the drop-in center in Region 4 (Corinth) may assist in providing technical assistance for new day support services in the northern part of the state.

Funding: Federal and state.

Was objective achieved? Yes

Improvements to the Psychosocial Rehabilitation Program

Goal: To continue to improve psychosocial rehabilitative services to better serve adults with serious mental illness.

Clubhouse Coalition

Objective: To continue a workgroup formed by DMH to ensure the quality of the psychosocial rehabilitation programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Clubhouse Coalition operation

Indicator: Meetings and activities of the Department of Mental Health Clubhouse Coalition: to include at a minimum, (1) continued development of performance measures for the clubhouse programs (such as employment, hospitalization rates and the impact on members' lives), (2) continue supporting a clubhouse staff working with ICCD to conduct site visits; (3) continuing strategies for providing orientation and technical assistance for clubhouse staff, focusing on job development; (4) addressing other tasks recommended by ICCD consultants; and (5) continuing to support Clubhouse Programs that are seeking ICCD certification.

Measure: The number of times per year the Department of Mental Health Clubhouse Coalition will meet (minimum of twice) and work accomplished on tasks described in Indicator.

Comparison/Narrative:

In FY 2008 there were three ICCD-certified clubhouses in Mississippi: in Region 5 (Greenville), in Region 6 (Greenwood) and in Region 12 (Hattiesburg). Region 5 has been officially defined by ICCD as a Welcome Center. In FY 2008, the Clubhouse Coalition met four times and continued to include members and staff who have participated in ICCD clubhouse training, both in-state and out-of-state. The coalition developed and approved performance measures for the clubhouse program. (1) The measures are being used in the two ICCD certified clubhouses and have been shared with Region 12 CMHC. (2) The Department of Mental Health continued to support two clubhouse house staff, one from each ICCD certified clubhouse and to conduct international site visits with the ICCD team. (3) The ICCD-certified clubhouse in Greenville, MS (Region 5) continued to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi. (4) An ICCD representative from Genesis Clubhouse in Worcester, Massachusetts, conducted a four-hour workshop on young adult initiatives at the 2007 Mississippi Mental Health Consumer Conference. The Genesis Clubhouse is certified to provide training on initiatives to attract young adults into the clubhouse program (5). One additional clubhouse program was pursuing ICCD certification in FY 2008 (Region 9). The certification date has been postponed to FY 2009.

In FY 2009 there were three ICCD-certified clubhouses in Mississippi: in Region 5 (Greenville), in Region 6 (Greenwood) and in Region 12 (Hattiesburg). Region 5 has been officially defined by ICCD as a Welcome Center. In FY 2009, the Clubhouse Coalition met two times and continued to include members and staff who have participated in ICCD clubhouse training, both in-state and out-of-state.

The Department of Mental Health continued to support the ICCD clubhouses with ICCD certification. The Department of Mental Health assisted region 5 (3 staff and 2 members) in attending the national clubhouse conference. DMH continues to support region 5 in maintaining a clubhouse thrift store in the community.

The ICCD-certified clubhouse in Greenville, MS (Region 5) continued to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi. Ann Macvaugh, Director of ICCD clubhouse in Greenville, provided technical assistance about ICCD certification to Region 9 CMHC.

Region 9 clubhouse is pursuing ICCD certification in FY 2000. The ICCD conducted the certification consultation visit in August, 2009. Region 9 is awaited certification results. Region 6 has submitted an application for ICCD certification on their Lexington clubhouse.

Source(s) of

Information: DMH Clubhouse Coalition Minutes

Special

Issues: None

Significance: Establishment of a Clubhouse Coalition was recommended by the ICCD, the certifying entity for clubhouse programs, to continue monitoring the quality of psychosocial rehabilitation/clubhouse programs in the state.

Funding: State funds

Was objective achieved? Yes

Training in the Clubhouse Model

Objective: To facilitate training of community mental health services staff and consumer members in the clubhouse model in accordance with the Internationally Certified Clubhouse Development (ICCD) program model, as well as staff in day support programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Psychosocial rehabilitative services – training support

Indicator: Availability of funds through DMH to partially support training provided at ICCD-certified site(s) located in-state and/or out-of-state for staff in targeted clubhouse program sites. The remainder of the funds not used for this training will be used to support: (1) provision of technical assistance in-state by representatives of ICCD training sites (such as Fountain House in New York, NY, Gateway House in Greenville, SC or other training sites located out-of-state or in-state, such as the clubhouse programs in Greenville, MS or Greenwood, MS); and (2) training and/or technical assistance in the

area of day support.

Measure: The number of: (1) clubhouse program sites that send staff to ICCD-certified sites for training and/or to which in-state technical assistance is made available; (2) program sites to which training/technical assistance in the area of day support is made available.

Comparison/Narrative:

In FY 2008 two CMHC regions (Regions 9 and 15) program sites received on site training from Washington Square clubhouse in Greenville, MS. Three staff persons and three members were trained. Additionally, Hinds Behavioral Health participated in training in October in Greenville, South Carolina. DMH staff members are scheduled to participate in training in Greenville, South Carolina in October, 2008.

In FY 2009, 12 people received from Region 7 received training from Washington Square clubhouse in Greenville, MS; eight staff persons and four members were trained. Six more staff are scheduled to attend the training in November. One staff member from Region 9 received technical assistance. Two DMH staff members attended the training in Greenville, South Carolina in October, 2008. The coordinator from Pine Belt Mental Health is scheduled to attend training in Greenville, S.C. in January.

Source(s) of Information: Program grants

Special Issues: Scheduling of training for individual regions over the next 12- to 18-month period will vary; therefore, data on the number of clubhouse program and day support program sites which send staff for training, both in-state and out-of-state, in the new plan year will be tracked. Emphasis in training/technical assistance for clubhouse programs will be placed on developing and maintaining transitional employment.

Significance: The need to increase training in the clubhouse model has been identified by the Clubhouse Task Force and by program monitors on certification/peer review visits. CMHS funds have continued to be used to assist in funding the cost to local programs of sending additional staff to ICCD sites for out-of-state training, as well as in funding the cost of out-of-state ICCD site representatives providing training in-state. CMHS funds will also be used to assist in supporting training/technical assistance for clubhouse programs at sites located in Mississippi (Greenville and/or Greenwood).

Funding: CMHS Block Grant

Was objective achieved? Yes

Note: This objective also addresses Criterion 5 (training).

Transitional Employment Program for Individuals With Serious Mental Illness

Objective: To provide technical assistance in improving implementation of the transitional employment component of the clubhouse rehabilitation program.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Psychosocial rehabilitation program - training support

Indicator: Availability of training/technical assistance through DMH, targeted at improving implementation of the transitional employment component of the clubhouse rehabilitation program.

Measure: The number of CMHC staff and/or CMHC regions to which additional training on transitional employment at the model clubhouse program site and/or additional in-state technical assistance on transitional employment (through consultants, depending on factors such as availability of the consultants and scheduling issues, or through in-state programs/peer review) is made will be tracked.

Comparison/Narrative:

In FY 2008, the DMH continued to make available training/technical assistance targeted at improving implementation of the transitional employment (TE) component of the clubhouse rehabilitation program. Additionally, DMH has made available funding to the two ICCD-certified clubhouses in the state (in Greenville and in Greenwood) to support their TEPs. DMH also has assisted Washington Square (Greenville) in the development of TE training for other clubhouse members and staff, which is currently incorporated into the one-week clubhouse training Washington Square provides. Staff and members from Washington Square continue to work with an ICCD representative to strengthen the TE component of the training. In FY 2008 DMH conducted employment workshops at the annual mental health consumer coalition. Additionally, in FY 2009, state human resource directors and private human resource directors will be invited to participate in the conference to learn more about the transitional employment program.

In FY 2009, state human resource directors and private sector human resource directors were invited to participate in the conference to learn more about the transitional employment program (TEP). TEP and supported employment were addressed with regard to the recovery model at this year's consumer conference.

Source(s) of

Information: Program grants and DMH documentation of training.

Special

Issues: Of the individuals who attend special training for clubhouse staff at the model training program, those who have previously completed the basic parts of the training can opt to also attend a one-week training component on transitional employment. Also, technical assistance on transitional employment will continue to be made available to targeted

regions by consultants and/or through in-state programs/peer review. The number of staff involved in these training/technical assistance initiatives will vary, depending on which regions participate and on availability of the consultants and scheduling issues. As mentioned previously, technical assistance on implementing the psychosocial rehabilitation/clubhouse program, including the transitional employment program component, is also available through the peer review process.

Significance: Increased training/technical assistance in the clubhouse model has continued to be available. The need to maintain training/technical assistance to address staff turnover and the needs of staff in new programs is anticipated, with particular focus on the transitional employment program component.

Funding: CMHS Block Grant

Was objective achieved? Yes

National Outcome Measure: Evidence-Based Practice – Supported Employment (URS Developmental Table 16)

As in previous years, the DMH has continued to collect/report information on the number of individuals served in transitional employment programs, as defined by the state. 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 employment. DMH has continued activities through its Data Infrastructure Grant (DIG) project that included work on the central data repository. These activities allow for reporting of supported employment services when they are available and when fidelity is established.

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 March 2009 was 7.7%, and the average unemployment rate for March 2009 was 9.4%.) DMH continued 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 4. 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) project in FY 2010 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 efforts to increase data integrity may result in adjustments to data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

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.

National Outcome Measure: Increased/Retained Employment (URS Table 4); Individuals employed as a percent of those served in the community.

DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 4: Profile of Adult Clients by Employment Status in FY 2005 through FY 2009. Using the most recent guidance received from the Center for Mental Health Services (CMHS) for reporting on the URS measure, the following baseline information has been collected:

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
Individuals employed as a percent of those served in the community	17.9%	17.5%	17%	16.2%
Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)	9219	9541	8670	9571
Denominator: # of persons employed + unemployed + not in labor force (excludes "not available" status)	51,451	54,473	51,000	59,211

Was objective achieved? Although the quantitative target was not reached by a small amount (.8%), the DMH Division of Community Services (DCS) continued to make available technical assistance on the transitional employment component of the clubhouse programs described previously in the State Plan. It is the goal of the DCS to offer more employment training options at the annual consumer conference as well as to expand relationships with agencies and coalitions, such as the Department of Rehabilitation Services, and the MS Transportation Coalition.

Vocational/Employment/Educational Services may also be accessed by community mental health centers and the community services divisions of East MS State Hospital, Mississippi State Hospital and Central Mississippi Residential Center 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, the Community Services Divisions of the two larger state hospitals and Central MS Residential Center 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 FY 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 Consumer Access to Affordable Housing and Supports

Group homes

Goal: To provide community-based housing options for persons with serious mental illness.

Objective: To continue to make group home options available in FY 2009.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of group homes

Indicator: Availability of 24 group homes.

Measure: The number of group homes available (Minimum: 24 group homes)

PI Data Table A1.8	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Availability of Group Homes	23	23	24*	24

*One group home (Cedar Point in Region 13 on the Gulf Coast) remained closed due to damage from Hurricane Katrina, but was reopened toward the end of FY 2006. Another home that was damaged in Region 12 was repaired and individuals are again residing there.

Comparative/Narrative:

In FY 2008, there were 23 homes certified by the Department of Mental Health, for a total of 248 beds. Additionally, DMH certified four homes (48 beds) operated by Central MS Residential Center in FY 2008.

In FY 2009, there were 24 Group Homes certified by the Department of Mental Health available for adults with serious mental illness. The total number of beds available in the 24 group homes was 257. The number of group homes by region is as follows: Region 2 (8 beds), Region 3 (9 beds), Region 5 (30 beds), Region 6 (24 beds), Region 12 (31 beds), Region 13 (24 beds), Region 15 (27 beds), East Mississippi State Hospital (77 beds), Mississippi State Hospital (27 beds).

Source(s) of

Information: DMH Monthly Resident Enrollment Forms; Adult Services Annual State Plan Survey, and Residential Monthly Summary Form.

Special

Issues: The number of group homes targeted was modified in the FY 2007 State Plan.

Significance: The need for affordable housing in Mississippi is very high. These group homes provide affordable housing, while providing individuals opportunities to increase independent living skills while they live in the home.

Funding: State and local funds

Was objective achieved? Yes

Transitional Residential Treatment Services or Halfway Houses

Objective: To continue to make available transitional residential treatment/halfway house options for adults with serious mental illness in need of this service for FY 2009

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of transitional residential treatment options

Indicator: Continued availability of transitional residential treatment/halfway house services in three locations (Greenwood (operated by Region 6, Life Help), Jackson (operated by MS State Hospital Division of Community Services) and Meridian (operated by East MS State Hospital Division of Community Services).

Measure: The number of beds available for adults with serious mental illness in transitional residential treatment/halfway house programs (30 beds).

PI Data Table A1.9	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Transitional Residential Services #beds	33 beds; 80 served	36 beds; 114 individuals served	30 beds	36; 80 individuals served

Comparison/Narrative:

In FY 2008, there were 36 beds certified in three transitional living programs, located in Greenwood (Region 6)- 16 beds; Jackson (operated by MSH Community Services) – 10 beds; and, Meridian (operated by EMSH Community Services) – 10 beds; these three programs reported serving a total of 114 adults with serious mental illness in FY 2008.

In FY 2009, as of October 2009, DMH certified three halfway houses. These were located in Greenwood (capacity 16), Enterprise (capacity 10) and Jackson (capacity 10); for a total capacity of 36 beds; these three programs reported serving a total of 80 adults with serious mental illness in FY 2009.

Source(s) of

Information: DMH Adult Services Annual State Plan Survey, Residential Monthly Summary Form, and Monthly Resident Enrollment Forms.

Special

Issues: None.

Significance: Transitional treatment programs provide a community-based therapeutic option to prevent rehospitalization of some individuals, to reduce hospital stays and/or for respite. Group therapy, individual therapy, money management, and independent living skills training are among the services offered through these programs.

Funding: Federal, state and local funds

Was objective achieved? Yes

Supervised housing

Objective: To provide supervised housing for adults with serious mental illness.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Supervised housing availability

Indicator: Availability of supervised housing options for adults with serious mental illness

Measure: The number of beds made available through supervised housing provided through CMHCs and state psychiatric hospital community services division(s) (150)

PI Data Table A1.10	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Availability of Supervised Housing	153	153	150	153

Comparison/Narrative:

In FY 2008, a total of 153 beds were available in DMH-certified supervised housing in six regions (Regions 5, 6, 7, 8, 14, 15) and through MSH Community Services Division.

In FY 2009, DMH certified 13 Supervised Housing Programs in six regions across the state, plus one Supervised Housing program operated through Mississippi State Hospital, with a total capacity of 153 beds. Region 5 (capacity 30), Region 6 (capacity 32), Region 7 (capacity 55), Region 8 (capacity 8), Region 14 (capacity 12) and Region 15 (capacity 8). Mississippi State Hospital had a capacity of 8 supervised housing beds. There are also HUD-funded supervised housing options in Region 4 (Capacity 78), Region 15 (17). An additional 24 supervised housing units were available during the first part of FY 2009, operated by Central Mississippi Residential Center; however, these units were closed in May 2009 due to budget cuts.

Source(s) of

Information: Adult Services Annual State Plan Survey and Residential Monthly Summary Forms.

Special**Issues:**

Supervised housing has become a preferred option for adults with serious mental illness. The DMH will continue to evaluate existing and new programs and explore funding options for the growth of this service. As noted in discussion of the NOM on supported housing that follows, data definitions and related data collection for housing options have continued to be reviewed and as data issues are addressed through FY 2009, adjustments in targets and/or reports are anticipated.

Significance: Supervised housing provides appropriate and affordable housing for persons with serious mental illness. This option allows persons with a serious mental illness to have more independence and provides an opportunity for them to learn independent living skills.

Funding: State and local funds

Was objective achieved? Yes

National Outcome Measure: Evidence-Based Practice – Supported Housing (URS Developmental Table 16)

DMH continued work in FY 2009 to develop capacity to collect data for evidence-based practices by the FY 2010 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 has continued activities through its Data

Infrastructure Grant (DIG) project that included work on the central data repository. These activities allow for reporting of supported housing services when they are available and when fidelity is established.

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 in FY 2009 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, therefore, trends will continue to be tracked for another year (in FY 2009) to better inform target setting in subsequent Plan years.

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 will also continue.

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

DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile in FY 2005 through FY 2007. Using the most recent guidance received from the Center for Mental Health Services (CMHS) for reporting on the URS measure, the following baseline information has been collected:

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
% of adults reported homeless/in shelters	.7%	.8%	.7%	.8%
Numerator: # adults reported homeless/in shelters by DMH certified/funded providers	402	512	402	560
Denominator: # adults reported in other living situations by DMH certified/funded providers	59,625	63,410	59,625	65,997

Was objective achieved? Although the target was not reached by a small margin (.1%), activities to provide assistance to homeless persons with mental illness continued. In FY 2009, as of April 2009, DMH Staff had participated in the bi-annual National PATH Conference in Alexandria, VA,

networking with State PATH Contacts from all 50 states, PATH Grant technical assistants, and federal administrators of the PATH Program. A DMH staff member 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 Partners to End Homeless meetings. Both of these groups are comprised of area organizations dedicated to serving persons experiencing homelessness. A “Project CONNECT Day” was held on September 22, 2008, in Jackson, MS, at which approximately 325 individuals experiencing homelessness received services.

Other Housing Assistance

In FY 2009, examples of housing assistance accessed by individual local community mental health providers for eligible individuals with serious mental illness included: federal low income housing (e.g., subsidized housing, rental assistance, Section 8), temporary emergency housing, shelter for victims of domestic violence, personal care homes, home buyer education, supportive housing, assistance with home ownership, emergency and transitional shelter programs, homeless shelter and transitional services, shelter services for persons with HIV/AIDS, and supervised apartments. Examples of agencies/entities in individual communities through which housing/housing assistance were access included: local housing authorities (and HUD), the Salvation Army, local community mental health centers, licensed personal care home providers, Stewpot Community Services, Gateway Rescue Mission, Grace House, Southern Christian Services for Children and Youth, St. Andrew’s Mission, University Center for Excellence and Developmental Disabilities, the American Red Cross, Gulf Coast Rescue Mission, a Community Action Agency, Gulf Coast Women’s Center, Lighthouse Ministries, the AIDS task force, and Habitat for Humanity.

Substance Abuse Services

As indicated in the FY 2008 and FY 2009 State Plans, substance abuse services were also administered by the Mississippi Department of Mental Health through the Bureau of Alcohol and Drug Abuse Services. Community mental health centers are the primary providers of both community mental health and outpatient substance abuse treatment for adults. Other nonprofit programs also provide some prevention and treatment services in the community, and public inpatient treatment services are provided through the Mississippi State Hospital in Whitfield (for men and women) and the East Mississippi State Hospital (for men). Initiatives to address the needs of individuals with co-occurring disorders are addressed in distinct objectives in the Plan.

Health/Medical and Dental Services/Other Support Services

- Goal:** To make available needed dental, medical, and/or other support services to adults with serious mental illness served through the public community mental health system.
- Objective:** Each CMHC in developing its community support services plan will design specific methods to facilitate access to medical, dental, and other support services.
- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system

Brief Name: Medical/dental/support service planning

Indicator: Annual development of a plan by CMHCs for providing medical, dental, and other support services (as part of application for CMHS Block Grant funds).

Measure: The number of CMHCs that develop an adequate community support services plan, which addresses the provision of medical, dental and other support services (15)

PI Data Table A1.11	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Community Services Plan has Provision of Medical, Dental, Other Support Services	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Comparison/Narrative:

In FY 2008, the Department of Mental Health continued to require that the 15 community mental health centers implement a plan for providing medical, dental, and other support services. The community mental health centers maintain a list of resources to provide medical, dental services which include general health services, inpatient hospital, preventative, family support, immunizations, TB screening, home health services, psychiatric evaluations/medication monitoring and communicable disease evaluation. This plan is submitted with the CMHS grant proposal and reviewed by a team of providers, peers, and a NAMI-MS representative. In FY 2008, specific examples of local providers through which services were accessed included: general outpatient medical services (including free walk-in clinics in some areas), prevention services, home health services, STD testing, emergency services, inpatient services, OB/GYN services, TB screening, podiatry, neurology services, psychiatric services, immunizations, medical detoxification services, hospice care, nutrition services, prescription assistance programs, vision care, general dental care (routine examinations and cleaning), emergency dental care, and preventive dental care.

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.

Source(s) of Information: Community support services plans submitted by CMHCs

Special Issues: None

Significance: The availability of local community support plans facilitates implementation of the ideal model of comprehensive mental health and support services needed for individuals to remain in the community.

Funding: Federal, State and local funds

Was objective achieved? Yes

Other Mental Health/Social Services

Examples of other mental health/support services (other than those listed previously) provided to adults with serious mental illness in FY 2009 as reported by individual community mental health centers and the Community Services Divisions of Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center included: food, clothing, home furnishings, transportation assistance, utilities assistance, general financial assistance, nutrition services, Meals on Wheels, family planning services, linkage and referral, medication assistance, emergency food and financial assistance, legal advice and representation, vision screening and eye glasses, homemaker services, Senior Companion program, representative payee services, laboratory services and dietary counseling. These services were reported as provided through a variety of community agencies and groups, such as local community hospitals, home health agencies, faith-based community organizations, the Salvation Army, the Social Security Administration, the Mental Health Association, the Mississippi Department of Human Services, the Mississippi Division of Medicaid, NAMI-MS, the American Red Cross, local civic clubs (e.g., Civitan Club, the Junior Auxiliary, garden clubs, the Lions Club), Mississippi Food Network, community food pantries, local pharmacies, Area Agencies on Aging, American Civil Liberties Union, the University of Southern Mississippi Institute of Disability Studies, Legal Aid, county Home Extension Services, the United Way, and the Mental Health Association.

Mental Health Case Management Services

Goal: To provide case management services to persons with serious mental illness.

Objective: To provide case management services to adults with serious mental illness who need and want this assistance.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case management service provision

Indicator: Continued availability of case management services to adults with serious mental illness who need and want the service.

Measure: The number of adults with serious mental illness who receive case management services in the fiscal year (15,500).

PI Data Table A1.12	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# Served–Case Management	16,781	15,331	15,500	15,811

Comparison/Narrative:

In FY 2008, community service providers reported 401 adult services case managers. They provided services to 15,331 adults with serious mental illness (including individuals with Medicaid) through the CMHCs and the Community Services Divisions of MS State Hospital and East MS State Hospital and through private non profit agencies that either received funding or certification through the Department of Mental Health. (See also objective on intensive case management.)

In FY 2009, community service providers reported 407 adult services case managers. They provided services to 15,811 adults with serious mental illness (including individuals with Medicaid) through the CMHCs and the Community Services Divisions of MS State Hospital and East MS State Hospital and through private non profit agencies that either received funding or certification through the Department of Mental Health. (See also objective on intensive case management.)

Source(s) of

Information: Annual State Plan Survey

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), to develop a central depository for data from the mental health system. As this system is implemented within the FY 2008-2009 time period, downward adjustments in targets are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed

Significance: The DMH requires all CMHCs and community services divisions of the state psychiatric hospitals to provide 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 diversions from hospitalization, particularly for those individuals with high inpatient recidivism rates.

Funding: State, SSBG, Medicaid, local funds

Was objective achieved? Yes

Objective: All 15 CMHCs will evaluate all adults, with a serious mental illness, who receive substantial public assistance for case management services.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case Management: Medicaid eligibility/service referral

Indicator: Case records will reflect that consumers receiving substantial public assistance will have case management explained, offered and refusals placed in writing.

Measure: The percentage of those records monitored that have documentation of meeting this requirement and the percentage cited as out of compliance by DMH with the applicable minimum standard will continue to be tracked. Records reviewed during certification/site visits will have documentation that case management has been explained and offered to eligible individuals with serious mental illness in need of the service, with refusals of service in writing included as part of the record.

Comparison/Narrative:

In FY 2008, 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. By the end of fiscal year 2008, 100% of the records reviewed for this requirement reflected that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusals placed in writing. No citations were issued in FY 2008.

In FY 2009, 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. By the end of fiscal year 2009, 100% of the records reviewed for this requirement reflected that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusals placed in writing. No citations were issued in FY 2009.

Source(s) of

Information: DMH Site Visit Documentation (review of records)

Special

Issues: None

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

Funding: State, SSBG, Medicaid, local funds

Was objective achieved? Yes

Intensive Case Management

Objective: To continue to provide funding to support implementation of intensive case management services.

- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system
- Brief Name:** Intensive case management support/assistance
- Indicator:** Continued availability of funding from DMH to support intensive case management.
- Measure:** The number of CMHC regions to which DMH makes funds available to support intensive case management (15 CMHCs)

PI Data Table A1.13	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
CMHCs Funded for Intensive Case Management	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Comparison/Narrative:

In FY 2008, CMHS Block Grant funding for this service was awarded at an approximate 2.8% decrease of the 2006 funding level. All 15 regions received awards ranging from \$35,601.00 to \$39,795.00 each to continue to provide intensive crisis services to those in need. These variations in funding levels occurred because providers were given the option to determine which federal (CMHS) program from which to take their portion of the CMHS funding cuts in FY 2006. Regions 4 and 8 were also provided additional funds to enhance intensive case management services.

In FY 2009, CMHS Block Grant funding for this service was awarded at an approximate 2.8% decrease of the 2006 funding level. All 15 regions received awards ranging from \$35,601.00 to \$39,795.00 each to continue to provide intensive crisis services to those in need. However, due to a decrease in federal funding, each provider had to take a \$1,000.00 across the board cut. These variations in funding levels occurred because providers were given the option to determine which federal (CMHS) program from which to take their portion of the CMHS funding cuts in FY 2006. The current awards range from \$34,601.00 to \$38,795.00. Regions 4 and 8 were also provided additional funds to enhance intensive case management/crisis response services.

Source(s) of

Information: Program grants and Monthly Summary Form.

Significance: Availability of intensive case management programs targeting services to those individuals with the most severe need (i.e., individuals with a dual diagnosis, individuals referred for civil commitment, those at high risk of rehospitalization, etc.) will help reduce their risk for hospitalization/rehospitalization.

Funding: CMHS Block Grant

Was objective achieved? Yes

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

Technical Assistance to Case Managers

Objective: To continue to address technical assistance and/or program improvement needs in case management programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case management support/assistance

Indicator: Continued availability of DMH technical assistance, resource identification and/or continuing education through the Case Management Task Force and through individual program visits.

Measure: The number of times Case Management Task Force meetings are held to provide technical assistance (at least four); and the number of individual program visits for case management technical assistance (as needed).

Comparison/Narrative:

In FY 2008, four (4) Case Management Task force meetings were held: in October 2007, January 2008, April 2008, and July 2008. The following are examples of topics/events addressed in the task force meetings: person-centered planning was added to Module 1 Case Management Orientation agenda for 2008, consistent with the Departments effort to promote recovery; input on proposed changes to the *Minimum* Standards for case management; in service training by Department of Rehabilitation Services staff on the Mississippi Partners for Informed Choice (M-PIC) program, focusing on the Ticket to Work and Work Incentives Improvement Act of 1999 and addressing the Ticket to Work Program and PASS program; updates on 2008 legislative and budget status throughout the session; provision of input to proposals for changes to the Medicaid State Plan; federal targeted case management provisions; team-building, including a presentation on “The Five Dysfunctions of Teams”; planning for National Case Management Week; recommendations for consolidation of standards requirements for case management across disability groups; and, a presentation on the *Solution Wellness* program.

In FY 2009, four (4) Case Management Task Force meetings were held: in October 2008, January 2009, April 2009, and July 2009. The following topics were discussed: proposed Medicaid State Plan Amendment Update; State of Community Services System Transformation Activities Briefing (by Jake Hutchins, Director, Division of Community Services); In Service: Integrating Consumers into the Workforce: A training that re-introduces the Recovery Model Concept and the benefits of integrating individuals receiving services into the workforce (by the Division of Consumer and Family Affairs Staff, Aurora Baugh, Linda Brown, and Signe Shackelford); Redesigning and Developing Transportation services for Persons living with Disabilities: A statewide approach (by Jan Larson, Global Strategies Inc.); In Service: Does Your Leadership Style Pass The Favoritism Test? (by Thaddeus J. Williams, Division of Community Services); Positive Changes in the Professional Licensure and Certification

Programs (by Scott Sumrall, Division of Professional Licensure and Certification); In Service: Completing the Puzzle “Interpreting and Enhancing Differential Diagnosis of Selected Mental Health Disorders” (by Dr. John Norton, Director, Medical Psychiatric Unit University of Mississippi Medical Center, sponsored by Eli Lilly); Discussion: Changes in Targeted Case Management Implications; review of unification effort for case management Services included in DMH Minimum Standards (by Thaddeus J. Williams, Division of Community Services); Review of National Case Management Appreciation Week Celebration Activities.

Source(s) of

Information: Minutes of Case Management Task Force meetings and documentation of technical assistance maintained by the Division of Community Services.

Special

Issues: The Case Management Task Force is made up of case management supervisors from the 15 CMHCs and the two larger state psychiatric hospitals’ community services divisions. The task force meets at least quarterly to review and further develop the delivery of case management services, including intensive case management, statewide.

Significance: Given the vital role played by case managers in the service system, the recent development of new case management service options and the ongoing provision and expansion of case management training programs, addressing technical assistance and program improvement in case management programs, focusing on a recovery-oriented approach, remains a priority of the DMH Division of Community Services.

Funding: State and local funds

Was objective achieved? Yes

Case Management Outreach

Objective: Public awareness of the availability of case management services will be promoted by making up to 5100 brochures available to community mental health service providers for use in public education activities.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Public awareness of case management

Indicator: Continued availability of printed brochures describing the availability/benefits of case management services to public community mental health service providers it funds/certifies for distribution to Medicaid recipients served by those providers.

Measure: The number of case management brochures distributed to public community mental health service providers (up to 5100 annually)

Comparison/Narrative:

In FY 2008 and FY 2009, 7,000 brochures were distributed to all providers and at various locations (each year). The 15 CMHCs, the Community Services Divisions of MSH and EMSH, and several private non-profit service agencies received (300 brochures each). The remaining brochures were distributed during Case Management Orientation, the Annual Conference on Homelessness, and local community health fairs, conferences and trainings.

Source(s) of

Information: DMH records of distribution of brochures

Special

Issues: None

Significance: The DMH recognizes that the dissemination of information is vital in increasing public awareness about services that are available.

Funding: State funds

Was objective achieved? Yes

Activities to Reduce Hospitalization

Community-Based Emergency Services Systems Development

Goal: To reduce the rate of hospitalization for individuals who are at high risk for re-hospitalization.

Intensive Case Management

Intensive Residential Treatment Programs

Objective: To provide continued funding support for three intensive residential treatment programs currently operated by CMHCs as part of emergency services systems.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Crisis/intensive residential programs

Indicator: Continued provision of funding to help support intensive residential programs in three CMHC regions (Regions 6, 13, and 15).

Measure: The number of CMHC regions that receive continued funding support for intensive residential programs. (Minimum of 3).

PI Data Table A1.15	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Funding – Intensive Residential Programs	3 CMHC Regions	3 CMHC Regions	3 CMHC Regions	3 CMHC Regions

Comparison/Narrative:

In FY 2008, the Division of Community Services continued to provide funding for three intensive residential facilities (in Regions 6, 13, 15). Region 13 is operating at full capacity with full staff. The three programs (Region 6, 13, and 15) served 1045 individuals in FY 2008. In FY 2009, the Division of Community Services continued to provide funding for three intensive residential facilities in Regions 6, 13 and 15. These programs are intended to provide immediate care to individuals in acute crisis. In FY 2009 these three programs served a total of 919 individuals.

Source(s) of

Information: Program Grants and Residential Monthly Summary Forms

Special

Issues: None

Significance: The implementation of comprehensive emergency services systems that include an intensive residential or crisis center treatment component will increase the accessibility of timely emergency/crisis services and further reduce hospitalization/rehospitalization.

Funding: State and local funds

Was objective achieved? Yes

National Outcome Measure: Evidence-Based Practice – Assertive Community Treatment (URS Developmental Table 16)

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 and plans to seek additional technical assistance from them in the summer of 2007. 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. DMH has continued activities through its Data Infrastructure Grant (DIG) project that included work on the central data repository. These activities have led to the establishment of new codes for reporting of evidence-based practices, including ACT, which will allow for reporting of ACT services when they are available and when fidelity is established.

Mental Health Transformation Activity: Improving Coordination of Care among Multiple Systems

Adult Making a Plan (AMAP) Teams

The three regions that were awarded block grant money to pilot AMAP teams are Region 6 (Greenwood), Region 7 (Starkville), and Region 8 (Brandon). All were chosen because they had strong support from their communities for their children's services MAP teams. The three regions have conducted 21 AMAP meeting and have provided wrap-around plans for approximately 35 adults with serious and persistent mental illness.

Mental Health Transformation Activity: Services for Individuals with Co-occurring Disorders (Mental Illness and Substance Abuse) (NFC Goals 4.3 and 5.3)

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.

Comparison/Narrative:

In FY 2008, the screening and assessment work group of the Co-occurring Disorders Coordinating Committee met and discussed options for different screening and assessment tools. The screening and assessment work group recommended that the GAIN short screener be implemented in all mental health regions throughout the state. The workforce development workgroup was developed and met several times throughout the year. The full Co-occurring Disorders Coordinating Committee met in August, 2008, and discussed implementing the GAIN screener statewide in community mental health and substance abuse programs and providing training on cognitive behavior therapy; the committee agreed unanimously to initiate both processes. DMH contracted with Region 12 (Pine Belt Mental Health) to provide organizational consultation, training, and clinical coaching to all fifteen regions in MS. Formal training will be offered on: assessment, reporting of diagnosis, and treatment planning for individuals with co-occurring disorders; evidence-based practices for providing services to individuals with co-occurring disorders; and, effective clinical supervision for enhanced clinical outcomes. With this formal training, ongoing clinical coaching and consulting specific to COD treatment will be provided. The first training session was provided in Region 15 in

September 2008. Also, in August 2008, the ATTC provided training on integrated treatment for persons with co-occurring disorders (SAMHSA’s Treatment Improvement Protocol (TIP) 42); 20 participants from different mental health centers and the DMH attended the training. The GAIN screener will be implemented statewide, beginning in FY 2009, and will be administered to individuals in community mental health and substance abuse programs.

In FY 2009, the Co-Occurring Disorders Coordinating Committee met in September, 2009, to review the progress of the consultation, training and clinical coaching initiative begun in FY 2008. As of September, 2009, eight of the 15 regions had received training, which was consistent with the two-year goal to have all 15 regions trained by the end of 2010. Also in FY 2009 the *GAIN Screener* for Co-Occurring disorders was implemented statewide.

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: SAPT block grant and state funds

Was objective achieved? Yes

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 Actual	FY 2009 Target	FY 2009 Actual
# Community Residential Dual Diagnosis Beds	12	12	12	12

Comparison/Narrative:

In FY 2008, \$238,376 (amount corrected for FY 2007) was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 17 individuals in FY 2008.

In FY 2009, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 35 individuals in FY 2009.

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

Was objective achieved? Yes

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 Target	FY 2009 Actual
# Served–Dual Diagnosis	8914	8598	6500	9295

Comparison/Narrative:

In FY 2008, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 8598 adults with co-occurring disorders of substance abuse and serious mental illness.

In FY 2009, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 9295 adults with co-occurring disorders of substance abuse and serious mental illness.

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

Was objective achieved? Yes

National Outcome Measure: Evidence-Based Practice – Integrated Treatment for Co-Occurring Disorders (URS Developmental Table 17)

The DMH continued to collect/report information in FY 2009 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 dual diagnosis 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, the proposed definition of which is similar to the approach being disseminated through training efforts in Mississippi. 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 2009, DMH continued work to develop the capacity to collect data on the aggregate total of individuals with dual diagnoses served in specialized programs. As noted, training has continued on use of a standard screening instrument for co-occurring disorders, the *Gain Screener*. DMH has continued activities through its Data Infrastructure Grant (DIG) project that included work on the central data repository. These activities have led to the establishment of new codes for reporting of evidence-based practices, including integrated treatment for co-occurring disorders, which will allow for reporting of those services when they are available and when fidelity is established.

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

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)

Family Education/Support and Consumer Education Support Programs

Goal: To provide family and consumer education and support services.

Objective: DMH will provide funding and support services for family education through the “Family to Family” program.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of family education program

Indicator: Information about the Family to Family education program offered by NAMI-MS will be made available to individuals with serious mental illness served through the public community mental health system, and their family members as appropriate.

Measure: The number of individuals receiving services through the Family to Family education program made available by NAMI-MS

Comparison/Narrative:

In FY 2008, the family education program was made available by NAMI-MS to all 15 CMHC regions across the state. As of September 2008, a total of five Family to Family classes had been conducted in five (5) regions (Regions 3, 4, 8, 9, 15), during which 64 individual family members were served. Additionally, 259 support groups were held in Regions 2, 3, 4, 6, 9, 10, 11, 12, 13, 14 and 15, and 1212 educational contacts were made. By the end of the fiscal year, no Family to Family Educators were trained, and 13 Support Group facilitators had been trained. Additionally, the NAMI Provider to Provider program was offered at Central Mississippi Residential Center (CMRC); there were eight class meetings, at which 37 providers were trained. There were 16 Provider Education teachers trained this year as well. NAMI also offered its Peer to Peer education program, in which 8 classes were offered in Regions 2, 4, 9, 13 and at CMRC. Seventy-one individuals attended, and seven facilitators were trained. Parent to Parent education programs were conducted in Regions 9, 11, 12, and 15, in which 43 individuals participated. NAMI also trained 25 presenters in Regions 2, 4, 8, 9, 10, 11, 12, 13, and 15 to facilitate the *In Our Own Voice* program.

In FY 2009, the family education program was made available by NAMI-MS to several CMHC regions across the state. As of September 2009, a total of five Family to Family classes had been conducted in three (3) regions (Regions 2, 9, 15), during which 60 individual family members were served. There were six Family to Family trainers

trained. Additionally, 380 support group meetings were held in Regions 2, 3, 4, 6, 9, 10, 13, 14, and 15. There were two Provider Education courses taught this year as well: one at North MS State Hospital and the other at Region 9 Hinds Behavioral Health Center; 44 providers attended. NAMI also offered its Peer to Peer education program, in which nine classes were offered in Regions 5, 6, 9, 10, 13 and at Central Mississippi Regional Center and MS State Hospital, Community Services (Jackson); 55 individuals attended. Additionally, 146 *In Our Own Voice* presentations were made to 3454 attendees. Forty individuals attended the five classes of NAMI Basics: Parent Program in Regions 11, 15, and Cares of Jackson.

Source(s) of

Information: “Family to Family” education program facilitators’ records (grant program records)

Special

Issues: As described in the Performance Indicator table that follows, currently, the MS DMH supports NAMI-MS in the provision of the Family to Family program, which reports the number of educational contacts made through that program. “Family psychosocial education” is an evidence-based practice included in the CMHS National Outcome Measures, the proposed definition of which is similar to the components used in the Family to Family Program. In accordance with current CMHS Reporting Guidelines for Evidence-based Practices (URS Table 17), DMH anticipates reporting data for the NAMI Family-to-Family program for FY 2009. DMH will continue to monitor availability of additional information on the effectiveness of the Family to Family program from ongoing research activities. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to address the issue of data collection for family psychoeducation. DMH is continuing work to develop capacity for collection of information for the National Outcome Indicators on evidence-based practices, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project.

The targeted number to be served through the Family to Family Program (80) was not completely reached in FY 2008, due to a smaller than expected turnout at two training sessions held in rural areas. Additionally, another training session was cancelled because of a low number of individuals planning to attend, and there were unanticipated problems with trainer scheduling because of illness. NAMI-MS has addressed this issue through increased outreach efforts; however, the number of individuals targeted to participate in the Family to Family program still reflects a decrease after FY 2008, due to reductions in availability of funding.

Significance: The “Family to Family” education program enables family members to become educated about their family member’s mental illness and facilitates the development of coping skills and support groups.

Action Plan: The NAMI Family to Family program services will continue to be made available to the families of 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 family education and support programs.

National Outcome Measure: Evidence-Based Practice - Family Psycho Education: (URS Developmental Table 17)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 Actual
Performance Indicator				
% receiving Family Psychoeducation Services*	.25%	.12%	.15%	.11%
Numerator: Number receiving Family Psycho education Services*	120	64*	65	60
Denominator: Number of adults with SMI served in public community mental health system (DMH funded)	48,493	52,312	42,000	53,910

*In accordance with *CMHS Reporting Guidelines for Evidence-based Practices*, it should be noted that numbers reflect individuals served through NAMI's Family –to-Family Program and not the evidence-based model referenced in SAMHSA's EBP Toolkit, which involves a clinician as part of clinical treatment.

Was objective achieved? The number receiving services was five less than the number targeted, which was attributed to a lower than projected attendance at one class held in the summer of 2009. The percentage achieved versus targeted was also affected by differences in the projected versus the achieved denominator in FY 2009.

Consumer Education/Support Programs

Objective: 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 Peer to Peer education program offered by NAMI-MS and 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 receiving services through the Peer to Peer program made available by NAMI-MS and who complete the Mississippi Leadership Academy (MLA)

Comparison/Narrative:

In FY 2008, the consumer education training programs were made available to all 15 CMHC regions. The Mississippi Leadership Academy (MLA) conducted two training events, resulting in a total of 34 graduates. The next academy session is scheduled for December 12-14, 2008, at Duncan Gray Conference Center; a goal of 20 graduates has been set for that class. The Director of the MLA has maintained contact with all graduates. Many of them report their leadership involvement with mental health training programs throughout the state (e.g., NAMI Peer to Peer; Mississippi State Mental Health Planning and Advisory Council; Consumer Coalition Conferences; peer reviews; peer advocacy) and other roles in their communities. At least six of the graduates have assumed lead roles on the MLA planning team. Five graduates are advisory board members at local CMHCs. The Director of MLA has incorporated material in the curriculum to strengthen peer reviews. The 2008 curriculum also addresses ways to foster better liaison between mental health services, consumers and law enforcement personnel. The MLA is designed to be offered twice a year, and 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 the community at large. Each class should include approximately 20 graduates. In FY 2008 BRIDGES had two ongoing support groups.

In FY 2009, the consumer education training programs were made available to all 15 CMHC regions. The Mississippi Leadership Academy (MLA) conducted one regular training event in December 2008 which produced 18 graduates, and in September 2009, which produced 17 graduates, bringing the total number of MLA graduates to 137. At least 13 of the graduates have assumed lead roles on the MLA planning team. The Director of MLA conducted an in-depth (two-day) Train-the-Trainer Workshop for 13 MLA graduates in February 2009. The newly formed MLA Board consists of 13 MLA graduates, and has met three times during this fiscal year (February, April and October). Thus, the MLA curriculum and classes are now totally supervised by this all-consumer board of officers. The Director of MLA had five MLA graduates as part of the teaching team for the September 2009 class. Future classes will increase the consumer participation in the organizational and teaching aspects of the academy. The goal is to have the academy be completely under the leadership of a statewide consumer coalition executive committee. NAMI also offered its Peer to Peer education program, in which nine classes were offered in Regions 5, 6, 9, 10, 13 and at Central Mississippi Regional Center and MS State Hospital, Community Services (Jackson); 55 individuals attended.

Source(s) of

Information: Consumer education program records; Grant program reports

Special

Issues: The Consumer Education Program provided or supported through the CMHC must be NAMI Peer to Peer, the Mississippi Leadership Academy or other program approved by the DMH.

Significance: The NAMI Peer to Peer training and Mississippi Leadership Academy are 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 program also provides information about how to access and advocate for and about opportunities for the development of self-help groups.

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, due to reductions in availability of funding.

Action Plan: The NAMI Peer to Peer program and 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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Mental Health Transformation Performance Indicator				
% of individuals receiving Illness Management/Recovery Services	.26	.20	.19	.14
Number Receiving Illness Management/Recovery Services*	127*	103*	80	73
Denominator: Number of adults with SMI served in public community mental health system (DMH funded)	48,493	52,312	42,000	53,910

*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).

Funding: State funds

Was objective achieved? The number receiving services was seven less than the number targeted in the FY 2009 State Plan modification (reduced because of funding limitations), which is probably due to a lower than anticipated attendance at sessions late in the year. The percentage achieved versus targeted was also affected by differences in the projected

versus the achieved denominator in FY 2009.

Other Educational/Support Opportunities

Objective: To make available educational opportunities and/or materials for consumers and to continue to make available support of the annual Mental Health Community Conference (attended by a significant number of consumers), as well as other local, state or national education/training opportunities.

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 at the annual Mental Health Community Conference, as well as other local, state or national education/training opportunities.

Measure: DMH will continue to make available support of the annual Mental Health Community Conference (attended by a significant number of consumers), including materials for hands-on participation in self-help workshops, as well as other local, state or national education/training opportunities.

Comparison/Narrative:

In FY 2008, the Central Mississippi Community Conference was held on May 29-30, 2008, at Mississippi State University's Riley Center in Meridian, MS. The North Mississippi Community Conference was held on June 5-6 at Oxford Convention Center in Oxford, MS. The South Mississippi Community Conference was held on June 19-20 at Lake Terrace in Hattiesburg. The conferences were attended by over 1,300 participants. The Department of Health cosponsored the conferences and conducted health screenings during the conference. The Mental Health Association of the Capital Area provided educational materials to consumers and family members. Pamphlets were provided to participants of the mental health conferences and other education materials were on display at the conferences.

In FY 2009, the Mississippi Mental Health Community Conference was held on May 29-30, 2009, at the Jackson Convention Center in Jackson, MS, and was attended by over 1,300 participants. The conference focused on Mental Health Recovery. Guest speakers included Dr. Dan Fisher, Executive Director of National Empowerment Center, and Mr. Larry Fricks, who currently serves as the Director of the Appalachian Consulting Group and Vice President of Peer Services for the Depression and Bipolar Support Alliance.

Special Issues: None

Significance: Continuing support of the Annual Mental Health Community Conference, as well as other local, state or national education/training opportunities, will facilitate or enhance the participation of consumers in opportunities to network with other consumers from various areas of the state who may have similar needs, interests and concerns. Examples of materials for workshop activities at the mental health community conference include journals, self-help books, etc., that participants can use in workshops and take home after the training. The provision of educational materials that consumers can borrow and/or keep, both through the conference and/or through a lending library or similar network will provide persons served within the community mental health system the opportunity to enhance their knowledge about mental illness and issues, concerns and resources within the state's public mental health system.

Funding: CMHS block grant

Was objective achieved? Yes

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

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 (25 in 2008) 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 *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.

Significance: The Department of Mental Health continues 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: As described in the State Plan (under Criterion 5), the DMH will continue support of law enforcement training provided by the CMHC and will continue efforts to include more community mental health centers in the training efforts. The DMH also plans to increase its networking efforts with the Department of Public Safety and other law enforcement and/or emergency services entities, and mental health providers to increase outreach 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.

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

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	76%	52%	64%	69%
Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	25	13	18	75
Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)	33	25	28	108

Was objective achieved? Yes

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

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: 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 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 has been 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 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: 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 (NAMI Peer to Peer and the Mississippi Leadership Academy), continued availability of training on person-centered planning and activities to develop peer specialist services, work with the consumer coalitions, and other activities 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 Target	FY 2009 Actual
Performance Indicator				
% age of Families of adult consumers reporting positively regarding social connectedness	75%	71%	73%	76%
Numerator: Number of adult consumers reporting positively about social connectedness	500	447	445	1112
Denominator: Total number of adult consumer responses regarding social connectedness	667	629	607	1470

Was objective achieved? Yes

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.

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. Since FY 2007, DMH has continued to work 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* 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 has been 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 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 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, activities 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 Target	FY 2009 Actual
Performance Indicator				
% age of Families of adult consumers reporting positively regarding functioning	69%	72%	71%	72%
Numerator: Number of families of adult consumers reporting positively about functioning	467	456	433	1053
Denominator: Total number of adult consumer responses regarding functioning	673	629	609	1458

The DMH is continuing work with the University of Mississippi Medical Center (UMMC) Center for Health Informatics and Patient Safety to administer the official version of the MHSIP Consumer Satisfaction Survey to a representative sample of adults with serious mental illness receiving services in the public community mental health system and plans to include results in the FY 2009 URS Table 9 submission. In its three-year federal Mental Health Data Infrastructure Grant for Quality Improvement funded by the Center for Mental Health Services, DMH also included an objective to provide training or technical assistance designed to increase the Planning Council's understanding and use of results of the satisfaction survey data, as well as other National Outcome Measures to facilitate its work and the work of its committees.

Was objective achieved? Yes

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 for FY 2004 – FY 2008. 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 by the end of FY 2009. 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 continued 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 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 FY 2009 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 for another year (in FY 2009) 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. 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 state psychiatric hospitals will provide routine reports on the number of readmissions by county to community mental health centers. Other planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will also be continued.

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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	2.43%	3.5%	2.40%	4.12%
Numerator: Number of civil readmissions to any state hospital within 30 days	84	134	82	175
Denominator: Total number of civil discharges in the year	3457	3845	3400	4244
2. Decreased Rate of Civil Readmissions to state hospitals within 180 days	12.79%	17.3%	12.75	15.62
Numerator: Number of civil readmissions to any state hospital within 180 days	442	665	434	663
Denominator: Total number of civil discharges in the year	3457	3845	3400	4244

Was objective achieved? The percentage of inpatient readmissions for adults at 30 days and 180 days was higher than targeted for FY 2009, although the percentage of readmissions at 180 days did decrease from FY 2008 to FY 2009. DMH will continue to monitor the NOM, and the target for FY 2010 will be reassessed.

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

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 2009 State Plan, 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 2009 Plan.

Comparison/Narrative:

In FY 2008, Mississippi utilized the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the (national) Center for Mental Health Services in the June 24, 1999, issue of the Federal Register, updating estimates using more current population data available from the 2000 U.S. Census. 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 in the State Plan, falls within the federal definition. 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.”

Estimates in the FY 2008 and FY 2009 State Plans were updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18

Mississippi

and older, by state 2006 and 2007, respectively, prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). The estimated number of adults in Mississippi, ages 18 years and above was 2,138,917, based on U.S. Census 2006 population estimates and 2,134,436 based on U.S. Census 2007 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 115,502 in 2006 and 115,260 in 2007. 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 non institutionalized 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.

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 National Association of Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS)

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

Was objective achieved? Yes

Target or Priority Population to be Served Under the State Plan

Quantitative Targets: Number of Individuals to be Served

National Outcome Measure: Increased Access to Services

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.
- Measure:** 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 in FY 2009 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 FY 2009 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 2009. As this system continues to be implemented within the FY 2008-2009 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. DMH continued 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 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 in FY 2010 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 2009.

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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Performance Indicator				
Total persons 18+ years served in public mental health system*	61,570	65,145	61,230	67,611

*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 through FY 2008, as duplication in reporting is addressed in ongoing data infrastructure development activities; downward adjustments are anticipated. ** FY 2009 preliminary results are also reported in the FY 2009 URS Table 2A and 2B submission and may be modified after review/edits by the National Research Institute (NRI) and the MS Department of Mental Health.

Was objective achieved? Yes

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.

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.)

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).

Quantitative Targets: Number of Individuals to be Served

Goal: To provide community support services 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 42,000)

PI Data Table A2.1	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# Adults with SMI Served	48,493	52,312	42,000	53,910

Comparison/Narrative: In FY 2008, a total of 52,312 adults with serious mental illness were served through the public community mental health system, which included 51,820 individuals served by the CMHCs and 492 adults served by the community services divisions of East MS State Hospital, Mississippi State Hospital and Central MS Residential Center. In FY 2009, a total of 53,910 adults with serious mental illness were served through the public community mental health system, which included 53,636 individuals served by the CMHCs and 274 adults served by the community services divisions of East MS State Hospital, Mississippi State Hospital and Central MS Residential Center.

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), to develop a central depository for data from the mental health system. As this system continues to be implemented within the FY 2008-2009 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 2009, 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.

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

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 – Second Year: “What a Difference a Friend Makes”

Indicator: To reach 200,000 individuals during FY 2009.

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	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2007 Plan	1.3 million individuals reached	200,000	900,000 (approximately)

Comparison/Narrative:

Although not an objective included in the FY 2007 State Plan document, DMH developed a statewide anti-stigma committee in March 2007. The committee consists of more than 40 representatives statewide from mental health facilities, community mental health centers, colleges, 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 “What a Difference a Friend Makes” campaign.

Mississippi

DMH developed a tracking system for presentations, newspaper/television/radio interviews, and other items for the statewide anti-stigma campaign. Since October 1, 2007 more than 20,000 anti-stigma brochures were distributed statewide. A majority of these brochures were distributed at Mississippi colleges and high schools. Members of the statewide Anti-Stigma Campaign have spoken at high schools and colleges throughout the state including Belhaven College, Mississippi State University Meridian Campus, Jackson State University, Ole Miss, Pearl High School and many more. In April 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. DMH made more than 25 presentations on the two topics including presentations for youth detention centers, MS Job Corp, National NAMI conference and the Mississippi Alliance for School Health conference. More than 4,000 individuals have been reached with these presentations.

In February 2008, more than 1,000 students in Newton County participated in the 1st Mental Health Awareness Day at Central Mississippi Residential Center. The day focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems.

Pearl High School students performed an anti-stigma skit at the annual legislative breakfast to more than 200 audience members. Students also created a DVD of the skit to be shown statewide during presentations. The DVD was unveiled during a DMH anti-stigma presentation at Pearl High School. The DVD and presentation was featured in several newspapers in Central Mississippi. An anti-stigma kickoff/health fair was also held in Meridian in October. More than 400 college students and adults attended the event.

Newspaper articles were printed statewide reaching more than 470,000 readers. A total of 10 television interviews have been conducted including interviews at WLOX in Biloxi, WLBT in Jackson and WTOK in Meridian. More than 386,000 viewers were reached with the television interviews. Committee members also participated in radio interviews statewide. More than 500,000 listeners from north Mississippi to south Mississippi were reached with radio interviews and public service announcements. From October 1, 2007 to September 30, 2008, more than 1.3 million individuals have seen (television interviews), read (newspaper articles/brochures) or heard (radio interviews and presentations) information about the anti-stigma campaign.

In FY 2009, DMH continued to expand its statewide anti-stigma campaign. The anti-stigma committee met four times throughout the year to discuss statewide efforts and to plan for the new anti-stigma campaign which was launched in October 2009. Since Oct. 1, 2008 more than 15,000 anti-stigma brochures were distributed. A majority of these brochures were distributed at Miss. colleges and high schools. Beginning in 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. Since October 1, 2008, DMH made more than 75 presentations on the two topics. Speaking engagements included high schools, middle schools, colleges, school counselors and nurses, and teachers and principals. Displays were set up at conferences statewide including the Governor's Obesity Conference, Jackson State University Mind and Body Fair, Looking to the Future Conference, and the Suicide Prevention Workshop. In January 2009, more than 1,500 students and teachers in Newton County participated in the 3rd Annual Mental Health Awareness Day at Central Miss. Residential Ctr. The day

focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems. In May 2009, DMH partnered with MSH and the Rankin County Chamber of Commerce to host the event, “Games Your Children Play” in Rankin county. The conference targeted parents, teachers, caregivers, etc. and discussed issues related to stigma and suicide prevention. More than 90 people attended the event. More than 55 newspaper articles discussing the stigma and suicide prevention were printed statewide since October 1, 2008 reaching more than 900,000 readers. DMH also participated in 12 radio interviews and eight television interviews to discuss stigma.

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

Was objective achieved? Yes

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)

Local Plans for Services for Elderly Persons

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 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Local Plans for Elderly Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

Comparison/Narrative:

By September 2008, all 15 CMHCs had submitted local plans for elderly services. The Elderly Task force met in October of 2007 and April of 2008. Members on the elderly psychosocial taskforce served as peers on three site visits. In FY 2008, there were 45 elderly psychosocial programs, including 25 elderly psychosocial programs in CMHCs and 20 elderly psychosocial programs in nursing homes in Regions 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, and 15.

By September 2009, all 15 CMHCs had submitted local plans for elderly services. The Elderly Task Force met in October of 2008 and August of 2009. In FY 2009, there were 61 elderly psychosocial programs, including 29 elderly psychosocial programs in CMHCs and 32 elderly psychosocial programs in nursing homes in Regions 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, and 15.

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

Was objective achieved? Yes

Elderly Psychosocial Rehabilitation Programs

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 Target	FY 2009 Actual
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 for 10 staff from elderly psychosocial rehabilitation programs	Training for 20 staff from the elderly psychosocial rehabilitation programs was provided

Comparison/Narrative:

The elderly psychosocial training site in Vicksburg, MS, provided training to 28 individuals, and the elderly psychosocial program in Hattiesburg, MS, provided training to five individuals, for a total of 33 staff trained in FY 2008. The Division of Community Services, along with the Division of Alzheimer’s Disease and Other Dementia, sponsored four one-day workshops on the early, middle, and late stages of Alzheimer’s disease throughout the state. Over 350 participants attended the workshops. In September 2008, the third elderly psychosocial training site for the nursing home programs was established in Greenwood, MS.

In FY 2009, the elderly psychosocial training site in Vicksburg, MS, provided training to eight individuals; the elderly psychosocial program in Hattiesburg, MS, provided training to eight individuals; and, the elderly psychosocial nursing home training site provided training to four individuals for a total of 20 staff trained in FY 2009. The Division of Community Services provided a one-day workshop “Caring for Our Senior Adults” in Hattiesburg, MS, with over 80 participants attending. A workshop for the northern part of the state is being planned for next year.

Source(s) of

Information: Division of Community Services monthly grant report forms

Special Issues: None

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

Was objective achieved? Yes

Annual Conference on Alzheimer’s Disease and Psychiatric Disorders in the Elderly

A DMH Division of Community Services staff continued to serve as a conference committee member for the annual statewide conference, Alzheimer’s Disease and Psychiatric Disorders in the Elderly to ensure that topics pertaining to psychiatric issues affecting elderly persons are addressed at the conference, such as depression and other types of mental illnesses. The conference, which included a pre-conference for physicians, was held in August 2009, and had over 700 registrants.

Specialized Outreach and Service Programs for Individuals with Serious Mental Illness who are Homeless/Potentially Homeless

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. (600)

PI Data Table A4.1	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# Served– Specialized Homeless	931	913	600	654

Comparison/Narrative:

In FY 2008, the five PATH-funded programs served 913 individuals by program as follows: MSH Community Services – 263; EMSH Community Services – 28; Gulf Coast Women’s Center – 66; Singing River Services – 28; Mental Health Association of MS – 528.

In FY 2009, the five PATH-funded programs served 654 individuals by program as follows: MSH Community Services - 192; EMSH Community Services -133; Gulf Coast Women’s Center - 74; Singing River Services - 48; Mental Health Association of Mississippi - 207. The decrease in numbers reported as served from FY 2008 to FY 2009 reflects a change/correction in reporting parameters: only contacts made with PATH-eligible individuals were reported in FY 2009; in previous years, all contacts with any homeless persons were reported.

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

Was objective achieved? Yes

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)

Comparison/Narrative:

In FY 2008, DMH staff participated in a two-day PATH Outreach Workshop in August 2008. A DMH Community Services staff person also participated in the Jackson Permanent Support Housing Workgroup, the task of which is to develop permanent housing for homeless persons in the Jackson area. A DMH Community Services staff member served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro dedicated to serving persons experiencing homelessness in the Jackson area. A "Project CONNECT Day" was held on September 23, 2008, in Jackson, MS, at which approximately 250 individuals experiencing homelessness received services. In FY 2008 DMH Community Services staff also attended meetings of the following organizations devoted to helping persons who are homeless: Partners to End Homelessness, MissionLinks, and Open Door Continuum meetings.

In FY 2009, DMH staff had participated in the bi-annual National PATH Conference in Alexandria, VA, networking with State PATH contacts from all 50 states, PATH Grant technical assistants, and federal administrators of the PATH Program. A DMH staff member 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.

Source(s) of

Information: Minutes of workgroup meetings and/or Division Activity Reports

Special

Issues: The DMH plans to continue operation of the Homeless Task Force it established to identify and plan for addressing the needs of homeless persons, including homeless persons with serious mental illness. 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.

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

Was objective achieved? Yes

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 Projected	FY 2009 Target	FY 2009 Actual
Local Plans Addressing Transportation	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHC's

Comparison/Narrative:

In FY 2008, all 15 CMHCs submitted community support plans, which were reviewed on March 19, 2008. In FY 2008, 15 CMHCs and the Community Services Divisions of MSH, EMSH and CMRC reported utilizing center-operated vans/other vehicles; 11 CMHCs and the Community Services Divisions of EMSH and CMRC reported making transportation available through affiliation agreement with other agencies; and, 12 CMHCs and the Community Services Divisions of EMSH, MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

In FY 2009, all 15 CMHCs submitted community support plans, which were reviewed by the DCS. In FY 2009, 15 CMHCs and the Community Services Divisions of MSH, EMSH and CMRC reported utilizing center-operated vans/other vehicles; 10 CMHCs reported making transportation available through affiliation agreement with other agencies; and, 11 CMHCs and the Community Services Divisions of EMSH, MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

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

Was objective achieved? Yes

Objective: Satellite offices or services of regional CMHCs located in 95% of the counties in MS that are designated as rural will make available mental health services to rural areas of the state.

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Availability of satellite community mental health center offices or services in rural counties.

Indicator: Satellite offices or services of regional CMHCs located in 95% of MS counties designated as 100% rural will make available mental health services.

Measure: The percentage of 100% rural counties in which satellite CMHC offices or services are located.

PI Data Table A4.3	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
% Rural Counties with CMHC Office	95%	95%	95%	95%
Numerator: # of rural counties with CMHC office/services*	20	20	20	20
Denominator: # of 100% rural counties in MS	21	21	21	21

* Typographical error in table from previous reports corrected to match wording of indicator/measure (added “services”), which were not changed.

Comparison/Narrative:

In FY 2008, satellite offices were located or services were available for mental health services in 95% of Mississippi counties designated as 100% rural. Sharkey and Issaquena counties share an office in Rolling Fork, MS (in Sharkey County).

In FY 2009, satellite offices were located or services were available for mental health services in 95% of Mississippi counties designated as 100% rural. Sharkey and Issaquena counties share an office in Rolling Fork, MS (in Sharkey County).

Source(s) of

Information: CMHC reports; 2000 Census information.

Special

Issues: *The numerator and denominator used in the targeted percentage for FY 2003 and subsequent years are based on the revised number of counties in the state designated as rural (21), based on U.S. Census 2000 information.

Significance: The location of satellite CMHC offices/services in rural counties increases the accessibility of some basic mental health services for consumers living in rural areas.

Funding: Medicaid, local, state, CMHS block grant funds

Was objective achieved? Yes

Objective: Psychiatric medication evaluations/monitoring will be available to individuals with serious mental illness in all counties in the state, as needed and appropriate

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Availability of medication evaluation/monitoring services in rural areas.

Indicator: Availability of medication evaluation/monitoring services, as needed and appropriate, through regional and/or county satellite offices/services of CMHCs.

Measure: Availability of psychiatric medication evaluations/monitoring, as needed and appropriate, to adults with serious mental illness through CMHCs.

PI Data Table A4.4	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Psych. Med. Eval. Availability (% County/Regional Offices/Services)	100%	100%	100%	100%
Numerator: Counties with access to med evaluations	82	82	82	82
Denominator: Counties in MS	82	82	82	82

Comparison/Narrative:

In FY 2008 and FY 2009, 15 CMHCs reported that medication evaluation/monitoring services were available to adults with serious mental illness living in all counties in their respective service regions.

Source(s) of Information: Annual State Plan Survey

Special Issues: CMHCs have continued since the implementation of the 1997 Mental Health Reform Act to increase the hours of physician time available to consumers.

Significance: Availability of medication/evaluation services to consumers in rural areas is important to their continued health and their ability to remain in the community.

Funding: Medicaid, local, state, CMHS block grant funds

Was objective achieved? Yes

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 2009). Efforts to Increase Funding**

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 2010 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 2010 DMH Budget Request.

Comparison/Narrative:

During the 2009 Legislative session, DMH requested the following increases in General State funds for Fiscal Year 2009 for community mental health services for adults: for deficit in Medicaid match on payments made to the regional community mental health centers - \$12,100,000; medication purchase - \$500,000; first year funding of services in

the Mississippi Access to Care (MAC) Plan - \$6,537,400. No additional funding was appropriated for the fiscal year that ends June 30, 2009. However, DMH did receive an additional \$10 million in General funds for the year that ended June 30, 2008, for match on Medicaid payments made to the regional community mental health centers, reducing by almost half the amount that was assessed to the CMHCs to fund the deficit.

Because of the significant financial problems facing the State of Mississippi during the 2009 Legislative Session, the Department of Mental Health limited its requested increase in State General funding to \$24,000,000 to fund the Medicaid match deficit for Medicaid receipts at the 15 regional community mental health centers, and \$1,006,678 to replace an anticipated cut of a like amount in federal Social Services Block Grant (SSBG) funding.

Prior to the “stimulus plan” (American Recovery and Reinvestment Act, or ARRA), Mississippi’s 15 CMHCs were projected to receive approximately \$141 million in Medicaid receipts during the fiscal year that began July 1, 2009. The state share of that was estimated to be \$34 million, and this is the amount that the Division of Medicaid was expected to bill DMH for match. Only \$10 million was expected to be available, though, so DMH asked for an increase of \$24 million to fully fund it. Absent that increase (or some part of it), the 15 mental health centers would, collectively, have been assessed to come up with the \$24 million using a formula that was based primarily on their actual Medicaid receipts (as has been the practice for the last approximately seven years).

Because of ARRA, Mississippi’s share of Medicaid match was reduced from 24.16% to 15.76%. This meant that the state share of \$141 million in Medicaid receipts would be reduced from about \$34 million to about \$22 million, a savings of \$12 million. Under the mistaken belief that the entire match need of \$34 million had been funded, the legislature “swept” \$12 million from DMH’s appropriation. Unfortunately, only \$10 million had been funded, which means that all of the appropriated funds for match were “swept” plus an additional \$2 million. Although DMH has been advising the legislature for years that the match was not fully funded, because of the intensity of the last days of the 2009 session, that simply got overlooked and by the time DMH knew this “sweep” had occurred, it was too late to fix it. (DMH did not have an appropriation until the 2nd Extraordinary Session, and the bill that was finally passed was signed by the Governor at 11:51 p.m. on June 30, 2009, the day before the new fiscal year began. DMH did not receive the bill or know the final results until mid-July).

Governor Barbour and key legislators have been made aware of this result and have pledged to do anything that can be done that is also fiscally responsible to address it during the 2010 legislative session. In the meantime, DMH has transferred about \$10 million of funds appropriated to other needs to be used for this Medicaid match. The remaining shortage of \$12 million will be assessed to the mental health centers. Approximate 45% of Medicaid match is for children and youth, and approximately 55% is for adults. In summary, no additional funding was received for Medicaid match and, a 100% cut was received. The anticipated cut to SSBG funding did not occur.

Source(s) of

Information: DMH Budget Request, FY 2010

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

Was objective achieved? Yes

Objective: To make available through DMH Substance Abuse Prevention and Treatment (SAPT) block grant funds to plan and provide services for individuals with dual disorders (mental health/ substance abuse).

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Availability of funds for services for individuals with dual diagnosis

Indicator: Continued availability of funds through DMH (Substance Abuse Prevention and Treatment Block Grant) to support provision of services to individuals with dual diagnoses (mental health/substance abuse).

Measure: The number of CMHCs to which funds to support provision of services for individuals with a dual diagnosis are made available (minimum of 15).

PI Data Table A5.1	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
Funding for Dual Diagnosis Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15

Comparison/Narrative:

In 2008, the DMH allocated \$1,169,132 (correction to FY 2007) from SAPT funds to the CMHCs for services to individuals with a dual diagnosis of mental illness and substance abuse. The DMH Bureau of Alcohol and Drug Abuse Services also hosted the first Mississippi Alcohol and Drug Studies School in FY 2008.

In FY 2009, the DMH allocated \$1,169,132 from SAPT funds to the CMHCs for services to individuals with a dual diagnosis of mental illness and substance abuse. DCS also granted \$37,000 to Region 12 to provided statewide training and implementation of the *GAIN Short Screener*.

Source(s) of Information: Monthly grant reports

Special Issues: As mentioned previously under Criterion 1, the Request for Proposals for applicants for dual diagnosis services funding (CMHCs) was revised to emphasize more specific information on the provision of integrated treatment and staff training.

Significance: Availability of funding for dual diagnosis services facilitates the development of services that are specialized to address the needs of individuals in this group, who may need more intensive treatment.

Funding: SAPT block grant funds

Was objective achieved? Yes

Objective: The DMH will provide funds from the Substance Abuse Prevention and Treatment block grant to operate a residential treatment program for individuals with co-occurring disorders (substance abuse/mental illness).

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Availability of funds for services for individuals with dual diagnosis

Indicator: Availability of Substance Abuse Prevention and Treatment block grant funds through DMH to support operation of a residential program for individuals with co-occurring disorders (mental illness/substance abuse).

Measure: The number of available beds in the community residential treatment program for individuals with co-occurring disorders (12)

Comparison/Narrative:

In FY 2008, \$238,376 (corrected for FY 2007) was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 17 individuals in FY 2008.

In FY 2009, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 35 individuals in FY 2009.

Source(s) of Information: Program grant reports

Significance: Availability of funding for this specialized treatment program provides an intensive community-based residential treatment option for individuals in this group.

Funding: SAPT block grant funds

Was objective achieved? Yes

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

Goal: To facilitate human resource development in addressing training needs of providers of mental health services to adults with serious mental illness.

Objective: To make case management orientation training available for staff hired as case managers in public community mental health programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case manager orientation program availability

Indicator: Availability of case management orientation sessions presented by the Department of Mental Health for case managers in public community mental health programs.

Measure: The number of times case management orientation sessions are presented during the year (eight).

PI Data Table A5.2	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# Case Management Training Sessions	8; 219 trained	8	8	7

Comparison/Narrative:

In FY 2008, the Department of Mental Health has continued to make available case management orientation training for staff hired as case managers in the public community mental health system. In FY 2008, DMH held eight case management orientation sessions (in October 2007; February, March, April, May, and July, 2008, and two sessions in September 2008). A total of 258 case managers completed case management orientation (Module I) in FY 2008.

In FY 2009, DMH held seven case management orientation sessions (in October 2008; February, March, April, May, and July, 2008, and one session in September 2009). A total of 180 case managers completed case management orientation (Module I) in FY

2009.

Source(s) of Information: DMH Training Records

Special Issues: None

Significance: Case management orientation sessions ensure training for case management staff in the areas of the Ideal System Model and continuity of service provision between providers. Case manager training is also a requirement in minimum services standards.

Funding: State funds

Was objective achieved? No, seven training sessions were held instead of the eight targeted. Eight training sessions were scheduled; however, only one of two training sessions scheduled for September was held because only one session had enough participants registered to justify holding the training.

Mental Health Transformation: Workforce Development

Mental Health Therapist Certification and Licensure Program

Mental Health Administrator Licensure Program

Case Manager Certification Program

Objective: To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Mental Health Administrator licensure program and the Case Management Certification program.

Population: Adults with Serious Mental Illness

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 Mental Health Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE).

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

Mental Health Administrator program; the number of individuals who hold a credential in the Case Management Certification program.

Comparison/Narrative:

In FY 2008, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 432 booklets were distributed. By the end of FY 2008 (September 30, 2008), a total of 1,959 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Provision of the Mental Health Core Training Program (MH-CTP) continued throughout FY 2008. The MH-CTP is comprised of three separate, week-long modules (Module I, Module II and Module III) each of which concludes with a written examination. In FY 2008, Module I was offered in January, April and July 2008. Module II was offered in March and September 2008. Module III was offered in October 2007 and again in May and August 2008.

In FY 2008, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 22 booklets were distributed. By the end of FY 2008 (September 30, 2008), the Licensed Mental Health Administrator program included a total of 122 individuals; 31 Program Participants and 91 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the six required written examinations. As of the most recent renewal deadline, December 31, 2007, approximately 70 renewing licensees reported having received 2,800 Contact Hours.

In FY 2008, PLACE staff continued to offer all six written exams for the Licensed Mental Health Administrator program in final form. Written examinations were made available to Participants one day each month. A total of 45 written examinations were administered to Participants in FY 2008.

In FY 2008, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; approximately 119 booklets were distributed. By the end of FY 2008 (September 30, 2008), a total of 629 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Provision of the Case Management Core Training Program (CM-CTP) continued throughout FY 2008. The CM-CTP is comprised of three separate training sessions (Module I, Module II and Module III) each of which concludes with a written examination. In FY 2007, Module I was made available in October 2006 and in February, March, April, May, July and September 2007. Module II was offered in October, November, January, February, March, April and May 2007 while Module III

was available on a quarterly basis. In FY 2008, Module I was made available in October 2007 and in February, March, April, May, July and September 2008. Module II was offered in November 2007 and March, May and September 2008. Module III continued to be made available on a quarterly basis.

In FY 2009, a change was made to the application process for individuals applying to move up (upgrade) from provisional certification to full certification that affected both the Mental Health Therapist Program and the Case Management Certification Program. It was decided that applicants would no longer be required to report continuing education hours at both the time of upgrade and the time of renewal. This was determined to be an unnecessary duplication of effort. Rather, we would continue to require continuing education to be addressed at the time of renewal.

In FY 2009, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 125 booklets were distributed. By the end of FY 2009, a total of 2,161 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Also in FY 2009, changes were made to the Mental Health Core Training Program (MH-CTP). The MH-CTP requirement was streamlined from three separate, week-long modules and written examinations to one written Mental Health Therapist examination with self-study as the basic format for test preparation. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009. The content of the remaining one written exam continues to be material outlined by a steering committee made up of community mental health service providers, consumer advocates, consumers/family members, administrators, etc. During FY 2009, the required Mental Health Therapist exam was administered to 146 individuals.

In FY 2009, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 15 booklets were distributed. By the end of FY 2009, the Licensed Mental Health Administrator program included a total of 126 individuals; 25 Program Participants and 101 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the required written examinations or his/her participation in DMH's leadership development program called Focus. As of the most recent renewal deadline, December 31, 2007, 68 renewing licensees reported having received the required 40 Contact Hours. The next renewal deadline will be December 31, 2009.

In FY 2009, PLACE staff continued to offer written exams for the Licensed Mental Health Administrator program. Written examinations were made available to Participants at least one day each month. A total of 2 written examinations were administered to Participants in FY 2009.

In FY 2009, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; 26 booklets were distributed. By the end of FY 2009, a total of 758 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Also in FY 2009, changes were made to the Case Management Core Training Program (CM-CTP). The CM-CTP requirement was streamlined from three separate modules and written examinations to one required training (Case Management Orientation) and written examination. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009.

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

Was objective achieved? Yes

The number of individuals who hold a credential in the Mental Health Therapist program, the number of Program Participants in the Mental Health Administrator program, and, the number of individuals who hold a credential in the Case Manager Certification Program in FY 2007 - FY 2008 and projected and actual numbers for FY 2009 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2009 (Actual)
Mental Health Therapists (all levels)	1,733	1959	1,973	2,161
Mental Health Administrators (all levels)	121	122	122	126
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	607	758
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Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in 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 a rotation in Region 15 (Warren-Yazoo Mental Health Services. The medical director in Yazoo County is also on the clinical faculty at UMMC, as are several of the psychiatrists and psychologists at MS State Hospital. 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 in early August 2008 for two community mental health centers (in Greenwood and in Clarksdale). In addition, the telepsychiatry service will link 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). The telepsychiatry project will receive additional funding from the Delta Health Alliance during the next fiscal year (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

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 Target	FY 2009 Actual
# Pre-evaluation Screening Training Sessions	8 sessions; 134 trained	6 sessions; 147 trained	4	6

Comparison/Narrative:

In FY 2008, consumers and family members shared their perspectives of going through the pre-evaluation screening process with CMHC staff being trained. Also, staff from Medicaid, AOP programs, Catholic Charities and DMH retardation facilities and hospitals participated in the training to enhance their understanding of mental health issues and as part of the DMH Module training. There were 6 sessions in which 147 individuals were trained.

In FY 2009, consumers and family members shared their perspectives of going through the pre-evaluation screening process with CMHC staff being trained. New staff from DMH, Mental Health Association of the Capital Area and the Mental Health Association of Mississippi also attended the training. There were 6 sessions in which 95 individuals were trained.

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

Was objective achieved? Yes

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

Goal: To provide training for emergency health workers regarding mental health.

Objective: To continue to collaborate with CMHC regions in providing training to law enforcement personnel.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Law enforcement training availability

Indicator: Availability of training using the Crisis Intervention Training Curriculum to recruits attending the six state law enforcement academies and to other law enforcement personnel in the field, upon request.

Measure: The number of CMHC regions to which the DMH will offer to collaborate to make available law enforcement personnel training in mental health.

PI Data Table A5.4	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual
# CMHCs collaborating with DMH	15 CMHC Regions; 12 regions participated; 37 sessions provided; 1,072 officers trained	15 CMHC Regions; 16 sessions; 467 officers trained	15 CMHC Regions	15 CMHC Regions; 42 training sessions, with 1443 law enforcement officers trained throughout the state.

Comparison/Narrative:

In FY 2008, DMH made funding available to 15 community mental health center regions for support of the provision of law enforcement training; 12 regions applied for and received the funding. A total of 16 training sessions were conducted, with 467 law enforcement officers trained throughout the state.

In FY 2009, DMH made funding available to 15 community mental health center regions for support of the provision of law enforcement training; 12 regions applied for and received the funding. A total of 42 training sessions were conducted, with 1,443 law enforcement officers trained throughout the state.

Source(s) of Information: DMH Training Records

Special

Issues: At the present time, minimum training, including the mental health training component, is required for law enforcement recruits. Training for experienced personnel in the field is provided on a voluntary basis, as requested.

Significance: The Department of Mental Health continues 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.

Funding: State, local funds

Was objective achieved? Yes

Information Management Systems Development

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 CMHS Data Infrastructure Grants, including the FY 2008-2010 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 FY 2008-2010 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.

Comparison/Narrative:

In FY 2008, DMH continued working closely with the ITS consultant and service providers on the development of the central data repository. DMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

As the process moves forward, aggregate data is still being collected. However, we are now starting to compare the aggregate data to the data compiled by the CDR.

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

There continues to be ongoing communication between DMH and the CMHC common data systems users group. This group meets six times yearly to discuss issues related to data collection, data reporting, and billing. DMH staff are invited members of the group and use it as a forum to discuss any data issues as well as state planning related matters. The ITS consultant working on development of the central data repository also attended these meetings. The meeting is open to all 15 CMHC regions. Minutes of the meetings are distributed to representatives of all CMHC regions.

In FY 2009, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Thirteen out of 15, or 87%, of regional community mental health centers (CMHCs) and two out of four, or 50%, of the state psychiatric hospitals are presently submitting data that populates the database.

The Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are about to embark on the task of setting up the Children's non-profits so they may enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables but we hope to have that task completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

Our continued approach has been to address collection, software upgrades, reporting quality, and training issues pertaining to the data at the local level, to bring all data from administrative sources into the central data repository by file upload and browser based data entry, to provide for monitoring of the data for accuracy and timeliness by Central Office personnel and to report the data to the CMHS in the form of the URS tables and in the State Plan as National Outcome Measures as required.

Ongoing technical assistance and training is also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training is also planned to facilitate communication among stakeholders.

Source(s) of

Information: Users Group meeting minutes; DIG grant reports

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

Was objective achieved? Yes

**(Amended) Projected FY 2009 CMHS Block Grant Projected Expenditures
by Type of Services for Adults with Serious Mental Illness**

<u>Service</u>	<u>Projected Est. Expend. FY 2009</u>
Individual Therapy	\$333,761
Medication Evaluation/Monitoring	\$79,523
Family Therapy	\$3,804
Group Therapy	\$26,283
Psychosocial Rehabilitation/Employment Enhancement	\$602,554
Nursing Services	\$43,340
IM/SC Administration of Psychotropic Medication	\$1,558
Case Management /ICM	\$740,829
Emergency	\$34,264
Community Residential	\$34,822
Training	\$8,000
Consumer Education	\$78,512
Family Education/Support	\$68,751
Peer Review/Technical Assistance	\$31,617
Drop-in Centers	\$77,408
Adult Making A Plan (AMAP) Teams	<u>\$29,315</u>
TOTAL	\$2,194,341

**(Amended) Projected FY 2009 CMHS Block Grant Projected
Projected Allocation of 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 Michael D. Roberts, Ph.D., Executive Director	\$126,368.13
Region III Mental Health Center 2434 S. Eason Boulevard Tupelo, MS 38801 Robert J. Smith, Executive Director	\$114,425.14
Timber Hills Mental Health Services P.O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Acting Executive Director	\$157,105.14
Delta Community Mental Health Services P.O. Box 5365 Greenville, MS 38704-5365 Richard Duggin, Interim Executive Director	\$135,283.13
Life Help P.O. Box 1505 Greenwood, MS 38930 Madolyn Smith, Executive Director	\$160,423.80
Community Counseling Services P.O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director	\$131,170.80
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director	\$132,045.79
Hinds Behavioral Health Services P.O. Box 7777 Jackson, MS 39284 Margaret L. Harris, Director	\$140,758.13

Mississippi

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	\$101,572.14
Warren-Yazoo Mental Health Services P.O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director	\$92,885.14
Mental Health Association of the Capital Area, Inc. 407 Briarwood Drive - Suite 208 Jackson, MS 39206 Debbie Holt, Executive Director	\$43,031
NAMI-MS 411 Briarwood Drive - Suite 401 Jackson, MS 39206 Larry Swearingen, Acting Executive Director	\$67,802.00
Mental Health Association of Mississippi P.O. Box 7329 4803 Harrison Circle Gulfport, MS 39507 Kay Denault, Executive Director	\$50,349

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 training for elderly psychosocial rehabilitative programs	\$ 9,000
Funds to support consumer education/training opportunities at annual state conference, as well as other local, state or national education/training opportunities	\$51,180.00
Funds to support enhancement of employment opportunities	Amt. included in awards for Region 5 & 6
Funds to support peer monitoring (Funds listed under DMH may be granted to local entities for implementation)	\$21,335.00
Total	<hr/> \$2,194,341

Note: A total of \$187,179 (5% of the total award to be spent on services in FY 2010 be used by the Mississippi Department of Mental Health for administration. It is projected that \$102,948 will be spent for administrative expenses related to adult community mental health services.