Part D:

Mississippi Department of Mental Health

FY 2011 State Plan Implementation Report

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II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2010	Estimate/Actual FY 2011
$1,897,209	$3,200,000	$3,239,843

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY ___X___ Federal FY _____

State Expenditures for Mental Health

Services		
Actual FY2009	**Actual FY 2010**	**Actual/Estimate FY 2011**
$40,000,000	**$33,000,000**	**$31,000,000**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

1. Summary of Areas Previously Indentified by State as Needing Improvement (from FY 2011 Plan)

Children's Services

- Continued funding, monitoring of implementation of local MAP Teams as well as plans for expansion to those counties with no access to a MAP Team. Continued work with MAP Teams to focus planning on increasing housing supports for youth with SED who may be at risk for homelessness.

- Increased use and availability of evidence-based practices through learning collaboratives focused on Trauma-focused Cognitive Behavioral Therapy (TF-CBT); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); and Combined Parent Child CBT. Increased training and supervisory of Wraparound services utilizing the University of Maryland, Innovation Institute's model.

- Continued training of local service providers and cross agency training on mental health issues in youth, system of care development, strengths-based assessment, a wraparound approach to services, and trauma-focused cognitive behavioral therapy, with focus on implementation of these concepts in the field.

- Continued work on interagency collaboration activities through State Level MAP Team, Interagency System of Care Council, State-wide Affinity Group and other interagency council and committees that focus on program, policies and services for children/youth and their families.

- Continued 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 monthly meetings of the state FASD Advisory Council.

- Continued collaboration with the education system through MAP Teams, the Interagency System of Care Council, the State Level Case Review Teams and the State-wide Affinity Group. DMH continues to require Community Mental Health Centers to offer school-based services to local school districts through Interagency Agreements.

- Continued implementation of the Juvenile Mental Health Initiative on training for detention center staff and the provision of mental health assessments and services to youth detained in the detention centers. Continued collaboration with the Department of Human Services (DHS), Division of Youth Services in the implementation of Adolescent "A" Teams and Adolescent Offender Programs (AOPs) for those youth with SED who are involved in the juvenile justice system.

- Continued implementation of a 3rd Comprehensive System of Care Initiative that targets transition-aged youth, 16-21 years. This Initiative, Mississippi Transitional Outreach Project

(MTOP) began implementation October 1, 2010 in 6 counties (two Community Mental Health Center regions and will expand to two additional counties October 1, 2011.

Adult Services

- In FY 2009 the Mississippi Legislature approved the Department of Mental Health Crisis Center Redesign Plan, permitting DMH to pilot the transition of operation of the state-operated crisis center in Grenada to operation as a crisis stabilization unit by Life Help Community Mental Health Center. In FY 2010 DMH sought and received legislative approval to transition the remaining six state-operated crisis centers from operation by the state hospitals to operation by regional community mental health centers. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of the remaining six units. The operation of all seven crisis stabilization units will be based on the redesign piloted in Grenada, which includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services. DMH has completed the transition of 6 of the 7 crisis stabilization units to CMHC operation. The CSU are taking voluntary and involuntary admissions and maintain a strong diversion rate of individuals who do not need to go into more restrictive treatment.

- Improving the quality of clubhouse psychosocial rehabilitation services throughout all service regions of the state and expanding the number of ICCD certified clubhouses to a minimum of one in each community mental health region in the state. Currently there are four ICCD-certified clubhouses in Mississippi: in Region 5 (Greenville), Region 6 (Greenwood), Region 12 (Hattiesburg), and Region 9 (Jackson). Region 5 has been officially defined by ICCD as a Welcome Center. A Clubhouse Coalition has been established and meets at least twice a year to discuss how to improve the clubhouse program. The coalition includes members and staff who have participated in ICCD clubhouse training, both in-state and out-of-state.

- Improving the quality and facilitating further development of psychosocial rehabilitation services for persons who are elderly throughout all service regions in the state, including community-based services and services for individuals in nursing homes. DMH continues to support three training sites for senior psychosocial programs across the state. These training sites are located in Vicksburg, MS, Hattiesburg, MS, and Kosciusko, MS. There has been an increase in the requests for training.

- Creating and maintaining a more person-directed service system for individuals with serious mental illness by incorporating person-centered philosophy throughout Department of Mental Health. As directed by its governing Board, DMH has been working diligently on an agency-wide Strategic Plan that addresses all areas of service responsibility. A major theme of the plan is to achieve a more person-directed service system, which will be reflected in the DMH standards review and revision process. In 2011, the peer review process was replaced with the Council on Quality Leadership Personal Outcome Measures 2005 ©. The Council On Quality and Leadership is International not-for-profit organization dedicated to being the leader for excellence in the definition, measurement, and evaluation of personal and community quality of life for people with disabilities and people with mental illness. Personal

Outcome Measures are a tool for evaluating personal quality of life and the degree to which organizations individualize supports to facilitate outcomes. People define outcomes for themselves. Personal outcomes are important because they put listening to and learning from the person at the center of organizational life.

- Continuing efforts to support and improve specialized programs for persons with mental illness who are homeless. DMH also applied for and received SOAR technical assistance to work with individuals who are homeless and have mental illness. DMH began its SOAR training initiative in February, 2011. Training in the SOAR program was provided by DMH for six organizations in the coastal region: Singing River Services, Gulf Coast Women's Center for Nonviolence, Mental Health Association of Mississippi, Gulf Coast Mental Health and Memorial Hospital of Biloxi. DMH has recently hired a full time housing coordinator who will assume the responsibilities for housing, PATH, SOAR and develop housing options and services across the continuum. The Housing Coordinator is expected to begin in January, 2012.

- Continuing initiatives to improve evidence-based services by providing training to address the full integration of services for individuals with co-occurring disorders of mental illness and substance abuse disorders. In 2010, DMH received federal Transformation Transfer Initiative funding that will facilitate training on effective assessment and treatment in community mental health regions and state hospitals that have not received the training in the previous year. DMH has provided training and follow up assessments to all service providers who requested training. DMH continues to develop funding streams which will allow integrated treatment for co-occurring disorders.

- DMH is in the final stages of revising its *Minimum Standards for Community Mental Health Services*. DMH will release new Operational Standards in January, 2012 and will begin training service providers on the revised standards and monitoring of programs.

- Increasing coordination of transportation services to address the needs and barriers experienced by individuals served in the public community mental health system and exploring funding opportunities to support piloting of initiatives developed by the Mississippi Coordinated Transportation Coalition. DMH received a TTI grant that will enhance the coordination of transportation services and service providers. In 2012, DMH will pilot a transportation project in Region 6 that will allow individuals to choose the transportation they need. DMH will assist with the cost of this project.

- Establishment of a Housing Task Force and initiation of a statewide strategic planning project to develop additional housing options for persons with serious mental illness. DMH has hired a housing coordinator, who will begin January, 2012.

- Continue working with the Division of Medicaid to develop a proposed State Plan Amendment and/or waiver for submission to the Centers for Medicare and Medicaid Services that, if approved, would facilitate changes in community-based services to further support resilience/recovery. The DOM has a proposed state plan that is in the 30 day public comment

period with the Secretary of State Office. DOM proposes these changes will begin in 2012.

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

1. Most Significant Events that Impacted the State Mental Health System in the Previous Year (from FY 2011 Plan)

Revised Operational Standards for Community Mental Health Services were implemented January 1, 2011, along with a new process for certification and monitoring visits. DMH streamlined the process for certification by conducting desk audits, revised checklists, and improving process for waiver requests and visited all programmatic locations during FY 2011 to ensure environment and safety standards were in compliance. DMH has plans to review all programmatic standards including manuals and client records during FY 2012-2013.

In 2011, a new process for Peer Monitoring was implemented utilizing the Council on Quality and Leadership's Personal Outcome Measures© in interviewing individuals receiving services, family members, mental health professionals and interested stakeholders. These interviews assist in determining the presence or absence of outcome and supports personal outcomes measures for adults, children and young adults and for families with young children. In FY 2011, the Arc of Mississippi and DMH trained thirty-seven individuals to conduct the interviews.

In March 2011, over 500 people attended a Mental Health Rally at the State Capitol to support minimum funding for education and mental health as proposed by the House of Representatives. The purpose of the rally was to support the public mental health system and minimum funding at the level recommended by the Legislative Budget Committee plus Medicaid match for Community Mental Health Centers. The Legislature did pass a budget for mental health totaling $249.3 million to keep existing services open including the seven Crisis Stabilization Units across the state. The overall budget was reduced by $7.7 million; however, the cut was taken from DMH operated facilities while

the funding level for community-based programs remained the same.

In the beginning of FY 2011, certified day treatment programs serving young children, ages 3-5 years was reduced. The Division of Medicaid implemented a Prior Authorization process for these programs serving 3-5 year old due to the intensive therapeutic nature of day treatment, which is defined as a behavioral intervention program which provides children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. It is the most intensive outpatient program available to children and should provide an alternative to residential treatment or psychiatric hospitalization. Prior authorization is the verification of medical necessity for this service prior to the delivery of day treatment. The Community Mental Health Centers' are responsible to secure prior authorization through Health Systems of Mississippi, the Utilization Management and Quality Improvement Organization contracted with Division of Medicaid. Due to increased demand on time and information required for prior authorization combined with denials of authorization; Community Mental Health Centers reduced the number of day treatment programs offered in their regions. DMH is currently working with Division of Medicaid to improve the prior authorization process for day treatment services for children/youth, 3-5 years of age.

The Department of Mental Health continued to address the following legislative initiatives in FY 2011:

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

House Bill 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). House Bill 1529, passed in 2010, deleted the automatic repealer, making the ICCCY a permanent body. It also expanded the membership to include the state Attorney General, youth and family members, a MAP team coordinator, a child psychiatrist, an early childhood education specialist, a self-advocate and a dean/faculty member from a Mississippi university.

Senate Bill 2894, passed in 2005, calls for the establishment and phasing in of "A" (Adolescent) teams modeled after MAP teams (described in detail in the State Plan under Criteria #1 and #3). The "A" teams will 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 includes 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 has continued 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.

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

House Bill 897, which passed during the 2009 Regular Session, which calls for the establishment of a Joint Legislative Study Committee and allows for the formation of an advisory council to that study committee. The committee is charged with studying and making recommendations for improving the mental health system and with making recommendations to the Legislature, including any recommended legislation, by December 1, 2009. Senate Bill 2645, which passed during the 2010 Regular Session, extended the study committee's work for another year with a final report due by January 2011. In addition, it expanded the Study Committee's focus to include the regional Community Mental Health Center system. Upon submission of their report, the committee was dissolved; however, legislation was introduced in the 2011 Regular Session (Senate Bill 2836) as a result of their work.

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

Senate Bill 2836, also known as the Rose Isabel Williams Mental Health Reform Act of 2011, passed during the 2011 Regular Session and included recommendations from the Joint Legislative Study Committee (House Bill 897 and Senate Bill 2645 above). It establishes that the goal of the state mental health delivery system is to provide services and supports to citizens in the communities where they live. It also requires that certain core services are to be available in each county. Each regional Community Mental Health Center is required to submit an annual operational plan clearly indicating which core services it will and will not provide. The Department of Mental Health is permitted to identify another provider for any core service not provided by a regional Community Mental Health Center. This legislation also provides for the appointment of a state-level Medical Director, the creation/membership/responsibilities of a 15-member Strategic Planning and Best Practices Committee to support strategic planning efforts already begun by the State Board of Mental Health, and the establishment of a new Department of Mental Health division responsible for implementing best practices.

House Bill 1177, which passed during the 2011 Regular Session, creates the Joint Legislative and Paraprofessional Education and Mental Health Study Committee. The purpose of this study committee is to assist in shaping public policy to improve student outcomes and educational

opportunities for students with serious emotional, behavioral disorders in regular and special education in the State of Mississippi and to make recommendations to the Mississippi Legislature. This study committee is comprised of members of the State House of Representatives and the State Senate, as well as a number of other state agencies, particularly individuals representing the field of education and the Community Mental Health Center system. The Mississippi Department of Mental Health also has one representative on this committee. This committee is charged with reporting to the Governor and Legislature by January 1, 2013, at which time the study committee will be dissolved.

3. Purpose for which the FY 2011 Block Grant Expended – Activities Description

See Criterion #5 of this Report of the Implementation Report for Children's Services (p. 124) and Adult Services (p.191).

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

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

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

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

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

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system

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

Indicator: A Recovery Self Assessment (Assessment) tool, adapted for applicability to children's services, has been developed to measure transformation from a traditional mental health service system to a recovery-oriented system of care. The primary goal of the assessment is to provide a tool that assists stakeholders to consistently track transformation activities in accordance with the Department of Mental Health's vision of developing a person driven, recovery oriented system of care.

Measure: Development of a Recovery Self Assessment tool to measure movement from the

traditional model to a recovery oriented system of care.

Comparison Narrative:

In FY 2010, the Peer Review Manual was updated, and is awaiting the DMH Standards revision and approval of selected recovery components to be incorporated into the peer review process. The Recovery/Resiliency Self Assessment was developed and is being reviewed by selected CMHC staff, consumers, family members, and interested stakeholders for feedback. This tool will be incorporated into the DMH Standards across all Bureaus to evaluate CMHCs, State hospitals and non-profit services/programs during the site visit process. The assessment for adult services will be adapted for applicability to children's services and is tentatively scheduled to be implemented with CMHCs in 2011.

In FY 2011, the peer review process was replaced with the Council on Quality Leadership Personal Outcome Measures 2005 ©. The Council On Quality and Leadership is International not-for-profit organization dedicated to being the leader for excellence in the definition, measurement, and evaluation of personal and community quality of life for people with disabilities and people with mental illness

Personal Outcome Measures are a tool for evaluating personal quality of life and the degree to which organizations individualize supports to facilitate outcomes. People define outcomes for themselves. Personal outcomes are important because they put listening to and learning from the person at the center of organizational life.

There are twenty one personal outcome measures for adults; twenty-two for children and young adults; and twenty for families and children under 5 years of age.

As of November 2011, thirty-seven individuals receiving services, family members, and mental health professionals have been trained to conduct personal outcome interviews. Personal outcome interviews have been conducted at LifeHelp (Region 6), Hinds Behavioral Health Services (Region 9), Gulf Coast Mental Health Center (Region 13), Community Counseling Services (Region 7), Weems Community Mental Health Center (Region 10), South Mississippi Regional Center, and East Mississippi State Hospital resulting in over 200 and/or children, young adults, or families and children under 5 years of ages.

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

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

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Results of the peer reviews make available

to providers additional information/technical assistance specific to their programs that can be used to improve services. The Recovery Self Assessment tools will allow the Department of Mental Health to assess how the community mental health centers and state hospitals identify strengths that already exist and acknowledge areas that require enhancement and further development.

Funding: CMHS Block Grant Funds

Was objective achieved? Yes

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

National Outcome Measure: Client Perception of Care – Outcomes

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system

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

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

Sources of Information: Results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH).

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

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

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

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
Performance Indicator					
% Reporting Positively about Outcomes for Children	65%	69%	68%	67%	67%
Numerator	198 positive responses	514 positive responses	369 positive responses		353 positive responses
Denominator	305 responses	742 responses	540 responses		528 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)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
1. % Reporting Positively about Access	87%	90%	89%	89%	88%
Numerator	264 positive responses	667 positive responses	477 positive responses		466 positive responses
Denominator	303 responses	742 responses	535 responses		529 responses
2. % Reporting Positively about General Satisfaction	88%	87%	88%	88%	90%
Numerator	266 positive responses	651 positive responses	481 positive responses		477 positive responses
Denominator	303 responses	745 responses	542 responses		532 responses
3. % Reporting Positively about Outcomes for Children	65%	69%	68%	67%	67%
Numerator	198 positive	514 positive	369 positive		353 positive

	responses	responses	responses		responses
Denominator	305 responses	742 responses	540 responses		528 responses
4. % Reporting on Participation in Treatment Planning for their Children	86%	89%	88%	87%	89%
Numerator	261 positive responses	662 positive responses	480 positive responses		470 positive responses
Denominator	303 responses	741 responses	541 responses		529 responses
5. % Reporting High Cultural Sensitivity of Staff (optional)	95%	94%	94%	94%	94%
Numerator	290 positive responses	701 positive responses	510 positive responses		494 positive responses
Denominator	305 responses	744 responses	540 responses		528 responses

Was objective achieved? Percentages reporting positively were slightly lower that targeted FY 2011 rates for the access domain (88% versus 89%). The percentage of parents/caregivers reporting positively about the general satisfaction, outcomes, treatment planning, and cultural sensitivity domains were as projected or higher than protected target rates.

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 2010, 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. OCS also provides all DMH bureau directors with quarterly informal and formal grievance reports indicating follow up and resolution of all complaints and grievances. OCS continues to update the statewide database used for information and referral. Approximately 60 new programs were added and over 500 individual program's information was updated in the reporting period. This process is ongoing. OCS contracted with the National Suicide Prevention Lifeline in December 2008 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 the beginning of FY 2010, OCS has received 7622 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. In January 2010, OCS contracted and developed the capacity to offer individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. OCS is also able to capture data and analyze trends related to the needs expressed by individuals. Since the inception of the program, there have been 189 messages sent and received, 1618 log-ins to the system and 122 individual user accounts created. Data from this program is included in the quarterly reports**.**

In FY 2011, 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

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

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

Mental Health Transformation Indicator: Data Table C1.2	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
Number of suicide awareness, prevention sessions/workshops	1 ASIST Training, 6 safe TALK presentations at workshop/seminars	1 ASIST Training, 4 safeTALK, presentations at workshop/seminar; 4 safeTALK; 5 presentations at workshops/seminars	Four presentations at workshops and seminars	Seven suicide prevention/ intervention trainings

Comparison Narrative:

In FY 2010, five suicide prevention presentations at workshops/seminars were conducted, four of which were safeTALK trainings to a local church group, social workers, mental health providers, and alcohol and drug abuse prevention staff. No ASIST Trainings were requested during FY 2010. In FY 2011, a Division of Children and Youth staff member will attend a training session for trainers to become a Certified ASIST Trainer.

In FY 2011, seven suicide prevention/intervention trainings were conducted (two of which were safeTALK trainings and two ASIST) to local non-profit agencies, mental health providers, youth detention center staff, faith-based organizations, MS Families As Allies, and two MS Transitional Outreach Project (MTOP) sites. Two Division staff continues to maintain their certification as ASIST trainers.

Strategy: Several DMH staff, as well as other staff from nonprofit service providers participating

on the Youth Suicide Prevention Advisory Council has been trained in ASIST and safeTALK. These staff conduct training upon request by mental health centers, universities, community colleges and other community agencies. Other members of the Youth Suicide Prevention and Advisory Council are available to conduct workshops and presentations on youth suicide prevention and awareness to community organizations, to other agencies, or at conferences, when requested.

Source of Information: Monthly Activity Reports Forms

Special Issues: None

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

Was objective achieved? Yes

Prevention/Early Identification and Intervention Services

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

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Prevention/specialized early intervention programs funded.

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

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

PI Data Table C1.2	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)

Prevention/Early Intervention– Funded Program	3 programs funded; 1105 children served	3 programs funded	2 programs funded; 439 children served	2 programs funded	2 programs funded; 170 children served

Comparison Narrative:

In FY 2010, DMH continued to provide funding to Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center. These two programs served 439 children and 128 families in FY 2010.

In FY 2011, DMH continued to provide funding to Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center. These two programs served 170 children and 93 families in FY 2011.

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

Special Issues: None

Significance: These programs provide specialized prevention/specialized early intervention services for targeted at-risk groups, including teen parents. One of these specialized programs collaborate**s** with local agencies in the community and with local MAP Teams to further enhance and develop wraparound services for children who have experienced sexual abuse. The program participates on a local multidisciplinary task force that has increased interaction with other professionals in local child service agencies. Children/youth with SED who are identified by this program receive prompt evaluation and referrals, and appropriate therapeutic intervention to address the abuse; parents receive effective parenting skills training and family interventions, as well as other interventions designed to reunify and/or improve family relationships where possible.

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

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Early intervention technical assistance

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

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

Comparison Narrative:

In FY 2010, eight CMHCs and Catholic Charities had 81 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) and Catholic Charities to encourage providers to make children's mental health services available to serve children.

In FY 2011, eight CMHCs had 22 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts were provided to six CMHC regions (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 including those children who screen positive for prenatal exposure to alcohol to identify problems and intervene as early as possible.

Funding: Federal, state, and local

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.

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

School-based Day Treatment will continue to be available in FY 2011, and the Division of Children and Youth Services will provide technical assistance to school-based day treatment sites as needed. During FY 2011, CMHCs reported a total of 307 day treatment programs, with 65 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 2011, a total of 29,153 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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual))	FY 2011 (Target)	FY 2011 (Actual)
Availability of School-based Outpatient	Offered by 15 CMHC Regions; 662 school-based	Offered by 15 CMHC Regions; 715	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions

Services (Offered to schools)	outpatient sites (FY data spans two school years).	school-based sites (FY data spans two school years).			

Comparison Narrative:

In FY 2010, a total of 27,749 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 the services; CMHCs reported having 645 school-based outpatient therapy sites. (Note: The number of school based sites reported span parts of two school years).

In FY 2011, a total of 29,153 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 the services; CMHCs reported having 682 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: 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

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
Regions w/ DMH Funding for Intensive Therapeutic Nursing Programs	2 regions funded	2 regions funded	2 regions funded	2 regions funded	2 Regions funded

Comparison Narrative:

In FY 2010, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2010, Region 4 nurses made 16,964 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 38,816 contacts, which included nursing assessments, medication monitoring and physical observations for those children receiving outpatient services.

In FY 2011, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2011, Region 4 nurses made 18,163 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 34,357 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 (100)

PI Data Table C1.9	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# New Respite Providers Trained	22 respite providers trained by MS FAA; Harden House trained		52 respite providers trained by MS FAA(of which 20 were new);		69 respite providers trained by MS FAA(of which 40 were new);

	64 respite providers; all providers trained were new.		Harden House trained 25 respite providers (of which 25 were new)		Harden House trained 65 respite providers (of which 3 were new)
# Respite Providers Available		50	MS FAA had 97 available providers; Harden House had 202 available providers	100	MS FAA had 81 available providers; Harden House had 78 available providers

Comparison Narrative:

In FY 2010, MS FAA provided training to 52 respite providers (of which 20 were new providers), and reported serving 264 youth; MS FAA reported 97 total respite providers available statewide. DMH also provided funding to Harden House, which provided respite training to 25 providers (of which 25 were new providers) and reported serving 360 youth in respite services in FY 2010; Harden House reported 202 respite providers available through their program.

In FY 2011, MS FAA provided training to 69 respite providers (of which 40 were new providers), and reported serving 429 youth; MS FAA reported 81 total respite providers available statewide. DMH also provided funding to Harden House, which provided respite training to 65 providers (of which 3 were new providers) and reported serving 216 children/youth ages seven months to nineteen years in respite services in FY 2011. Harden House reported 78 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.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

Comparison Narrative:

In FY 2010, DMH continued to make funding available to Catholic Charities, Inc to help support 24 licensed therapeutic foster care homes. Catholic Charities provided therapeutic foster care to 22 youth in FY 2010. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 211 youth. Nine certification, follow up and/or technical assistance visits were made to the six therapeutic foster care providers.

In FY 2011, DMH continued to make funding available to Catholic Charities, Inc to help support 30 licensed therapeutic foster care homes. Catholic Charities provided therapeutic foster care to 27 youth in FY 2011. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 207 youth.

Sources of

Information: Division of Children/Youth Services Program grant reports

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

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

Action Plan: DMH will continue to provide funding to the evidence-based therapeutic foster care program operated by Catholic Charities, Inc. The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by DMH. In FY 2009, visits to provide technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages in Jackson, Methodist Children's Ministries, and Mississippi Children's Home Services in Jackson and on the Gulf Coast., Stepping Stones, Catholic Charities, and Harden House. As of May 2010, technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages and Mississippi Children's Home Services.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
Percentage of					

children with SED served who received therapeutic foster care services*	.09	.11	.07	.07	.08
Numerator: Number Receiving Therapeutic Foster Care Services*	27*	23*	22	22	27
Denominator: Number of children with SED served by the state mental health agency (community services)	29,269	21,000	31,488	28,500	32,629

*See Special Issues section, before performance indicator table.

Was objective achieved? Yes

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)

# Funded Therapeutic Group Homes	Funding for support of 12 homes was allocated, but one of the homes was not yet opened at the end of FY 2008; 209 children served through homes with DMH funding support; An additional 201 youth served through homes certified, but not funded by DMH	Funding for support of 9 homes was allocated; 219 children served through homes with DMH funding support; An additional 257 youth served through homes certified, but not funded by DMH	Nine	Nine	Nine

Comparison Narrative:

In FY 2010, DMH continued to make funding available for nine therapeutic group homes. A total of 188 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 (89 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (31 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 (32 served)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (17 served)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (19 served)

Also, an additional 261 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. (16)
- Millcreek Therapeutic Group Homes (two homes) operated by Millcreek Rehabilitation Center (43)

- Paul's Home for Children group homes (two homes in Sturgis and in Columbus), operated by Southern Foundation for Homeless Children (38)
- 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) (85)
- Savior of Life (females), in Jackson (26)
- Saint Joshua's Therapeutic Group Home (males), in Jackson (6)
- Treasure House, operated by Positive Living, Inc. in Jackson (23)
- PALS Transitional Therapeutic Group Homes (two homes, Jackson) (7)

In FY 2011, DMH continued to make funding available for nine therapeutic group homes. A total of 231 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 (132 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (25 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 (45 served)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (15 served)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (14 served)

Also, an additional 302 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. (16)
- Millcreek Therapeutic Group Homes (two homes) operated by Millcreek Rehabilitation Center (38)
- Paul's Home for Children group homes (two homes in Sturgis and in Columbus), operated by Southern Foundation for Homeless Children (42)
- The Taylor House Group Home, (males) , operated by The Taylor House Group Home Inc., Greenville (8)
- Bass Group Home (females), Clarksdale, Gulf Coast Girls (females) Gulfport McRae Home (females) Jackson, Pendleton Home (Natchez), and Waters Home (males) Vicksburg operated by United Methodist Ministries for Children and Families-(males and females) (109)
- Savior of Life (females), in Jackson (30)

- Saint Joshua's Therapeutic Group Home (males), in Jackson (26)
- Treasure House, operated by Positive Living, Inc. in Jackson (22)
- PALS Transitional Therapeutic Group Homes (two homes, Jackson) (11)

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

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

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

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

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. In addition to the therapeutic community-based residential programs described previously in this section, examples of housing assistance reported as accessed by individual community mental health children's service providers in FY 2011 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 additional to local housing authorities, examples of other organizations assisting with housing included HOPE Credit Union, Habitat for Humanity, local MAP teams, Transitional Outreach Programs, the Salvation Army, PRVO, and local faith-based organizations.

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

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

Target: To continue support and/or funding for an outreach coordinator and intensive crisis

intervention services to youth/families served through these programs.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

Indicator: Number of youth served in the public community mental health system, reported as homeless/in shelters

Measure: Number of youth reported as homeless/in shelters as a percentage of youth served in the public community mental health system

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

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

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

Action Plan: DMH will continue to provide funding and support for **two** specialized programs serving homeless children/youth with SED, described in separate objectives under Criterion 4 in the State Plan. Gulf Coast Women's Center for Nonviolence

provides shelter for children and their mothers who are experiencing violence at home. Through Gulf Coast Mental Health Center, a therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the local shelter. The local shelter services children who have allegedly experienced abuse and/or neglect

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 (Actual)**	**FY 2009 (Actual)**	**FY 2010 (Actual)**	**FY 2011 (Target)**	**FY 2011 (Actual)**
Performance Indicator					
% of youth reported homeless/in shelters	.25%	.2%	.49%	.2%	**.**54
Numerator: # youth reported homeless/in shelters by DMH certified/funded providers	78	63	162	81	192
Denominator: # All youth reported with living situations by DMH certified/funded providers, excluding Living Situation Not Available	31,099	29,622	32,997	30,825	35,297

Was objective achieved? No, however, the action plan was implemented. Both the number of youth with living situations and the number of youth reported as homeless/in shelters increased. The reason for this increase is not apparent from this data.

Services to Special Populations

Mental Health Transformation Activity: Support for Services for Youth with Co-occurring

Disorders (Mental Illness and Substance Abuse) (NFG 5.2)

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

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

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

Criterion: Comprehensive, community-based mental health system.

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

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

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

Comparison Narrative:

In FY 2010, 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 Bureau of Alcohol and Drug Abuse Services 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.

A Division of Children & Youth Services staff member co-presented with a staff member from Bureau of Alcohol and Drug Abuse and the Executive Director for DREAM, Inc. for a teacher orientation workshop sponsored by one of the school districts in north Mississippi.

In FY 2011, the Director of the Division of Children and Youth Services continued to participate on the Fetal Alcohol Spectrum Disorders (FASD) Task Force, Epidemiological Outcomes Workgroup, Co-Occurring Disorders Coordinating Committee, and the Underage Drinking Task Force (MAUUD). 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, Specialized Treatment Facility, and the Bradley Al Sanders Adolescent Complex which serve youth with co-occurring disorders. The Division of Children and youth also sponsored and participated in 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. Staff from both divisions are members of Mississippians Allied Against Underage Drinking (MAAUD), the statewide underage drinking taskforce.

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 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
FASD screenings conducted	800	1,471	2000	6,142

Comparison Narrative:

In FY 2010, CMHCs screened 1,471 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.

In FY 2011, CMHCs screened 6,142 children ages birth to eighteen 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 DMH Division of Children and Youth Services encourages and supports screening children with a serious emotional disturbance for possible fetal alcohol spectrum disorders in those cases where indicated in order to provide identification of problems and intervention as early as possible.

Funding: Federal, state and/or local funds

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 2010

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

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

Comparison Narrative:

In FY 2010, 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 fourth 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 3rd Annual Mississippi School for Addiction Professionals held in January 2010, provided several break out sessions on youth with co-occurring disorders. Additionally, the Annual Lookin' To the Future Conference held in July 2010 had eight sessions targeted on alcohol and drug abuse in youth including addiction treatment for youth, trends in alcohol/drug use among teens, the psychological dynamics of addiction, effective interventions, scope of practice for addiction counselors, the impact of substance abuse on adolescent's cognitive development, and dangerous drugs in medicine cabinets.

In FY 2011, a designated Children and Youth Services staff member continued to participate on the Co-Occurring Disorders Coordinating Committee. Additionally, the System of Care Project (commUNITY cares), now in its fifth year of implementation and serving children/youth with SED and/or co-occurring SED and substance misuse in Forrest, Lamar and Marion Counties, continues to provide workshops specifically addressing co-occurring disorders; topics such as strength-based wraparound approaches and *The Seven Challenges* program were included. The 4th Mississippi School for Addiction Professionals held in April 2011, provided several break out sessions on youth with co-occurring disorders. Additionally, the Annual Lookin' To

the Future Conference held in June 2011 included sessions targeted on alcohol and drug abuse in youth including addiction treatment for youth, trends in alcohol/drug use among teens, the psychological dynamics of addiction, effective interventions, scope of practice for addiction counselors, the impact of substance abuse on adolescent's cognitive development, and dangerous drugs in medicine cabinets.

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

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

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

Funding: Federal and state

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 2011.

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

PI Data Table C1.12	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Beds Funded Residential Treatment Program	56 beds available; 146 youth served	56 beds available; 137 youth served	56 beds available; 102 youth	56 beds available	56 beds available

			served		

Comparison Narrative:

In FY 2010, the three programs served 102 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in a community based residential treatment. Sunflower Landing served 43 youth (32 of whom had co-occurring disorders) and the ARK served 33 youth, 33 of whom had co-occurring disorders). CART House closed June 30, 2010; in FY 2010, CART House served 26 youth, 16 of whom had co-occurring disorders.

In FY 2011, the two programs served 93 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in a community based residential treatment. Sunflower Landing served 45 youth (28 of whom had co-occurring disorders) and the ARK served 48 youth (44 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

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

In FY 2010, two CMHCs (Regions 3 and 10) provided school-based day treatment programs for children and youth with co-occurring disorders of mental illness and intellectual/developmental disabilities.

In FY 2011, three CMHCs (Regions 3, 8, and 10) provided school-based day treatment programs for children and youth with co-occurring disorders of mental illness and intellectual/developmental disabilities.

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

Multicultural Task Force

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Multicultural Task Force operation

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

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

Comparison Narrative:

In FY 2010, the Multicultural Task Force had met on November 23, 2009, and April 16, 2010, June, 24, 2010, August 19, 2010. The task force organized the statewide Day of Diversity that was held on October 13, 2009. The annual report to the Planning Council was presented by the Co-Chair of the task force on April 22, 2010. On September 1-2, 2010, several task force members attended the "Building a Community of Diversity: Understanding Cultural Competency workshop". The workshop was a collaboration between Department of Mental Health, MTOP and commUNITYcares. The presenters were Dr. Ken Martinez, lead for the TA Partnership's Cultural Competence Action Team and Holiday Simmons, community educator in the Southern Regional Office of Lambda Legal. The co-chair was one of the organizers of the workshop. On September 22, 2010, the co-chair of the Multicultural Task Force presented at the 2010 Rural Behavioral in Glendale, Arizona, with Dr. Vivian Jackson on "Disparities within Disparities: A Look at the 5 A's Through the Eyes of Person of African Heritage in Rural America".

In FY 2011, Multicultural Task have met on December 3, 2010 and March 25, 2011, May 20, 2011 and August 19, 2011. The task force organized the statewide Day of Diversity which occurred on October 13, 2010. The annual report, presented by a task force member to the Planning Council, was presented on August 13, 2011. The task force members received updates on the Mississippi Transitional Outreach Project (MTOP), Cultural Competency Plan, and Strategic Plan. The task force also discussed implementing a language access plan. Task force members attended the "Building a Community of Diversity: Understanding Cultural Competence, Part II conference on September 22 – 23, 2011. The co-chair of the task force served as a presenter and organizer for the conference. The conference was a collaboration between the Department of Mental Health and commUNITYcares. The co-chair also served on the

conference committee for the "Innovative Mental Health Services: Building Relationships and Strengthening Diverse Communities" This conference was a partnership with Southern Institute for Mental Health Advocacy, Research and Training (SMHART) Jackson State University, and Latasha Norman Center for Counseling and Psychological Services.

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

Cultural Competency Plan

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, community-based mental health system
Brief Name: Implementation Cultural Competency Workgroup

Indicator: Meeting/activity by the Cultural Competency Workgroup

Measure: The development of the committee and number of meetings

Comparison Narrative:

This objective was not included in the FY 2010 State Plan.

In FY 2011, the Department of Mental Health Cultural Competence

Implementation Workgroup was established. The workgroup has representation by individual receiving services, Adult Services, Children Services, IT Department, Alcohol and Drug Services, IDD and Prevention Services. The committee has met three times this year. The committee has updated the Cultural Competency Action Plans and made changes to the Cultural Competency Implementation Workgroup Strategic Plan. The workgroup has completed several targeted strategies/activities related to the plan. In addition, the workgroup recommended standards for the DMH Operational Standards related to linguistic competency. These recommendations are now included in the DMH Operational Standards. The workgroup has also made recommendations to include specific data collection questions in DRA to capture additional data related to cultural competency.

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

Special Issues: None

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

Funding: State Funds

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:

In FY 2010, the Multicultural Task Force had met on November 23, 2009, and April

16, 2010, June, 24, 2010, August 19, 2010. The task force organized the statewide Day of Diversity that was held on October 13, 2009. The annual report to the Planning Council was presented by the Co-Chair of the task force on April 22, 2010. On September 1-2, 2010, several task force members attended the "Building a Community of Diversity: Understanding Cultural Competency workshop". The workshop was a collaboration between Department of Mental Health, MTOP and commUNITYcares. The presenters were Dr. Ken Martinez, lead for the TA Partnership's Cultural Competence Action Team and Holiday Simmons, community educator in the Southern Regional Office of Lambda Legal. The co-chair was one of the organizers of the workshop. On September 22, 2010, the co-chair of the Multicultural Task Force presented at the 2010 Rural Behavioral in Glendale, Arizona, with Dr. Vivian Jackson on "Disparities within Disparities: A Look at the 5 A's Through the Eyes of Person of African Heritage in Rural America".

In FY 2011, Weems Mental Health Center agreed to participate in the cultural competency assessment project. The meeting was held with the Executive Director and a staff member on May 3, 2011, The assessment was Administered on May 26, 2011, to staff who represented the different service areas provided by Weems Mental Health. The mental health center received the results on October 20, 2011, during a meeting with the Executive Director and a staff member. The Executive Director provided a list of actions that will be taken regarding the results of the assessment on October 24, 2011.

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:

In FY 2010, NCBI training sessions were conducted with MS FAA on April 23, 2010, Timber Hills Mental Health Services on June 11, 2010, Singing River Services on July 29 and 30, 2010, (two separate trainings) and Communicare on August 25, 2010. Approximately 60 individuals attended. Children/youth service providers had the opportunity to participate in their local CMHC Day of Diversity activities in October 2009. A staff of the Division of Children and Youth made a cultural competency presentation at the 2009 Mississippi Black Leadership Summit: "Expanding Our Ranks Unleashing Our Power". Members have attended workshops on Disparities Among Native Americans, Resources for Spanish-speaking Communities National Networks of Libraries of Medicine, and Eliminating Mental Health Disparities: Challenges and Opportunities.

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.

In FY 2011, NCBI trainings were conducted on October 14, 2010, at Alcorn State University, July 6, 2011, and July 7, 2011, at the Winston Choctaw Correctional Facility, and July 8, 2011, at Region 1 Mental Health Center. The co-chair of the Multicultural Task Force (MCTF) conducted cultural competency trainings with law enforcement personnel in Lauderdale County and at Singing River Services, Communicare, Life Help, and Holly Springs Junior High School.

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 exiting high school) through the Office of Vocational Rehabilitation and Vocational Rehabilitation for the Blind in the Mississippi Department of Rehabilitation Services, in accordance with federal eligibility criteria and guidelines. General vocational rehabilitation services include a range of services from diagnosis and evaluation to vocational training and job placement. Additionally, a youth eligible for general vocational rehabilitation services might receive assistance with medical and/or health needs, special equipment counseling or other assistance that would enhance employability for a specific vocational outcome**.** Other specialized vocational rehabilitation services can also be accessed based on the youth's potential for a specific vocation. Supported employment, a specialized vocational rehabilitation service, is available to youth and adults who demonstrate more severe disabilities and who need ongoing job support to retain employment.

A representative of the Mississippi Department of Rehabilitation Services continued to attend State-level Interagency Case Review/MAP Team meetings. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, also participated on the Transitional Services Task Force and provided members with information on meeting the employment needs of youth in the transitional age range (18 to 25 years). The Executive Director of the Department of Rehabilitation Services continues to serve on the state executive-level Interagency Coordinating Council for Children and Youth (ICCCY) a representative continues to participate on the mid-management state level Interagency System of Care Council/ISCC (legislatively authorized in same legislation authorizing the ICCCY). (Current chairpersons are from the Mississippi Department of Mental Health.)

Specific examples reported of vocational/employment services accessed for youth by individual children's community mental health service providers included: independent living skills training, occupational therapy and development, GED programs, job training and placement, interviewing training, life skills assessment, supported employment, job coaching, , work readiness programs, basic technical skills training, resume and application assistance, and technology training. These services were provided through a variety of state and local resources and providers, which can vary

across communities, such as: Job Corps, the Mississippi State Employment Security Commission, WIN Job Centers, the Mississippi Department of Rehabilitation Services, local school districts, Allied Enterprises, Recruitment/Training Program of Mississippi, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, Ability Works of Mississippi, county vocational-technical centers, Youth Challenge Program, the Mississippi Department of Human Services, MIDD, MIDD West Industries, Pine Belt Mental Healthcare Resources Transitional Outreach Program, Pine Belt Graphics, PALS, Youth Challenge, Jackson State University, and community colleges.

Substance Abuse Services

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

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

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

In March 2006, BADA was awarded funds by the CSAP for a State Epidemiological Outcomes Workgroup (SEOW). In October 2006 this grant was incorporated into the newly awarded Strategic Prevention Framework State Incentive Grant (SPF SIG). 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. The priority of the SPFSIG is to reduce alcohol use and related consequences to include alcohol-related motor vehicle crashes, binge drinking and drinking and driving among youth between the ages of 11 and 21. Successful applicants will implement evidence-based programs, policies, and practices that address this priority.

Tobacco prevention

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

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

Substance Abuse Services for Adults and Children

Community mental health centers, free-standing programs and two state-operated psychiatric hospitals are the primary providers of substance abuse treatment. The existing substance abuse treatment system components administered by the Bureau of Alcohol and Drug Abuse which address the needs of both adults and children are described below:

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided these services. One of the free-standing programs, Metro Counseling Center provides day

treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care. In FY 2010, there were 6,844 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 2010, there were 1,317 adults and 505 adolescents who received these services.

Chemical Dependency Unit Services: Inpatient or hospital-based facilities offer services to these individuals with more severe substance abuse problems and who require a medically-based environment. Treatment includes detoxification, individual, group and family therapy, education services and family counseling. BADA continued to make available funding to one adolescent inpatient program, which is the Bradley Sanders Complex, an extension of East MS State Hospital, served 90 youth in FY 2010.

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Primary Residential Services: These services are for persons who need intensive residential treatment who are addicted to alcohol and drug problems. Services are easily accessible and responsive to the needs of the individual. In residential treatment, various treatment modalities are available, including individual and group therapy; family therapy; education services; vocational and rehabilitation services; recreational and social services. Adolescents who need primary residential treatment for alcohol and drug problems are provided intensive intervention. Individual, group and family counseling are offered as well as education programs at the appropriate academic levels. Adults and adolescents with a co-occurring disorder of mental illness and substance abuse are also provided treatment in a primary residential setting. These services are provided by 14 community mental health programs, 11 certified free-standing programs and three community-based treatment programs for adolescents programs. In FY 2010, there were 3,873 adults and adolescents who received these services; 341 adolescents were served in the three specialized programs.

Transitional Residential Services: These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program before being eligible for admission to a transitional residential program. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2010, there were 1,258 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 2010, there were 5,012 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 2010, the Office of Constituency Services received and processed 2,628 calls requesting substance abuse information or assistance in finding treatment and/or other related/support services**.**

Employee Assistance Program: During FY 2010, the Employee Assistance Coordinator updated and distributed the Employee Assistance Handbook to representatives of state agencies and organizations. The handbook entails the development of an employee assistance program including federal and state laws regarding a drug free workplace. The coordinator continued to provide EAP trainings across the state.

Specialized/Support Services: These services include vocational rehabilitation provided to individuals in local transitional residential treatment programs through a contract between the Bureau of Alcohol and Drug Abuse and the Department of Rehabilitation Services. 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 2010, 5,012 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 2010, there were 2,546 individuals who were eligible for DUI services and 1,669 inmates at the Mississippi State Penitentiary who were eligible for the residential alcohol and drug abuse treatment program.

Private Resources

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 52 licensed and/or Certificate of Need (CON) approved beds in FY 2010 for adolescents. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

Health/Medical and Dental Services

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

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

Mississippi Health Benefits is a cumulative term for the programs available for uninsured children. These include traditional Medicaid and the Children's Health Insurance Program The same application is used by individuals to apply for Mississippi Medicaid and CHIP. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP.

Applications and redeterminations can be made at the 30 Regional Medicaid Offices, as well as additional outstation locations. Outstation locations include: local health departments, hospitals, and Federally Qualified Health Centers.

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 157 delivery sites in Mississippi serving approximately 300,000 patients and further advancing President Obama's effort to provide access to health care for all Americans. Community Health Centers are located in high need areas identified as having elevated poverty, higher than average infant mortality, and where few physicians practice. These health centers tailor services to meet the special needs and priorities of their communities. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers who provide high quality care, thus reducing health disparities and improving patient outcomes. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale. However, no one is refused care due to inability to pay for services. These community health centers provide cost effective care and reduce emergency room, hospital and specialty care visits, thus saving the health care system between $9.9 and $17.6 billion a year. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

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

management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age. Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. DOH partners with other state agencies and organizations to address child and adolescent issues through active participation with, but not limited to, the local MAP teams, State Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

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

The Mississippi Department of Health's Office of Oral Health assesses oral health status and needs and mobilizes community partnerships to link people to population-based oral health services to improve the oral health of Mississippi children and families. The Mississippi Regional Oral Health Consultants are licensed dental hygienists in each Public Health District who perform oral health screening and education and provide preventive fluoride varnish applications to prioritized populations, such as children enrolled in Head Start programs. The Public Water Fluoridation Program is a collaboration with the Bower Foundation to provide grant funds to public water systems to install community water fluoridation programs.

The Mississippi State Department of Health (MSDH) recommends that every child begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. The MSDH Office of Oral Health can provide guidance on how to perform an oral health risk assessment and several risk assessment tools are available through the American Academy of Pediatrics, the American Association of Pediatric Dentistry, and the American Dental Association. Groups at higher risk for having dental caries, or tooth decay, include children with special health care needs, children of mothers with a high dental caries rate, children with demonstrable dental caries, plaque, demineralization, and/or staining, children who sleep with a bottle

or breastfeed throughout the night, later-order offspring, and children in families of low socioeconomic status. The MSDH recommends that infants in risk groups should be referred to a dentist as early as 6 months of age and no later than 6 months after the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home with education and early prevention services.

The Primary Health Care Association reports that the availability of dental care and oral health care for underprivileged individuals has increased in communities where federally-funded Community Health Centers are located. Currently 19 of the 21 Community Health Centers (CHCs) offer oral health services. Two of the CHCs receive federal funding to provide health care to the homeless populations, focusing on mental health and substance abuse, in addition to medical care. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

Mental Health Case Management Services

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 (14,000)

PI Data Table C1.14	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)

# SED Receiving Case Management	14,995	14, 666	15,181	14,000	15,248

Comparison Narrative:

In FY 2010, 15,181 children with serious emotional disturbance, including children receiving Medicaid, were reported as having received case management services through the CMHCs. In FY 2010, 294 CMHC case managers provided services to children/youth with SED; 57 of these case managers were reported to also have served adults.

In FY 2011, 15,248 children with serious emotional disturbance, including children receiving Medicaid, were reported as having received case management services through the CMHCs. In FY 2011, 337 CMHC case managers provided services to children/youth with SED; 95 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, 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

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Funded Crisis Response Programs	5	5	5	5	5

Comparison Narrative:

In FY 2010, 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 to include a mobile crisis line and mobile crisis team, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. The third model, operated by Pine Belt Mental 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 one experienced Bachelor's level case manager with knowledge in crisis intervention, six Master's level therapists on call 24 hours a day for all four counties, and two 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.

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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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Funded Intensive Crisis Intervention Projects	5	5	5	5	5

Comparison Narrative:

In FY 2010, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. Region 3 CMHC served 127 youth; Region 13 served 320 youth; Region 15 served 71 youth; Gulf Coast Women's Center served 178 youth; and MS Families as Allies for Children Mental Health, Inc. served 262 youth.

In FY 2011, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. Region 3 CMHC served 64 youth; Region 13 served 403 youth; Region 15 served 62 youth; Gulf Coast Women's Center served 160 youth; and MS Families as Allies for Children Mental Health, Inc. served 207 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. Data has not been submitted from Mississippi Families As Allies.

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Family Education Groups	8 family education/support groups were available through MS FAA (Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, and Hancock counties)				
# Family Workshops/Training Opportunities Provided/Sponsored	MS FAA provided 19 family workshops/training opportunities with 220 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS	MS FAA provided 20 family workshops/training opportunities with 247 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS	15	20	MS FAA provided 32 family workshops/training opportunities with 187 participants; six Parent to Parent (NAMI Basics) classes provided by NAMI-MS

Comparison Narrative:

In FY 2010, DMH continued to make funding available for family education and

family support. In FY 2010, Mississippi Families As Allies for Children's Mental Health, Inc. made available 18 family education/support groups and provided family workshops and training opportunities involving 334 participants. NAMI-MS has replaced Visions for Tomorrow and Parent to Parent classes with NAMI-Basics. There were 2 Parent to Parent (NAMI Basics) classes with 16 participants (9 meetings/ 8 contacts) and 27 Parent Support Meetings with 221 participants in FY 2010. Additionally, in 2009, Region 10 was funded for parenting education classes for the parents of children with SED involved in the juvenile detention center and alternative school. The parent education course meets weekly for 35 classes and has served 78 families.

In FY 2011, DMH continued to make funding available for family education and family support. In FY 2011, Mississippi Families As Allies for Children's Mental Health, Inc. made available 37 family education/support groups and provided family workshops and training opportunities involving 187 participants. NAMI-MS provided 6 NAMI Basics (Parent to Parent) classes with 62 participants and 10 Parent Support Meetings with 80 participants in FY 2011. Additionally, Region 10 was funded for parenting education classes for the parents of children with SED involved in the juvenile detention center and alternative school. The parent education course met two times weekly and has served 28 families.

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

Special Issues: None

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

Funding: Federal and state funds

Was objective achieved? Yes

Other Activities Leading to Reduction of Hospitalization

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health services

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

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

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

Special Issues: DMH is continuing work on development of the data system to support collection of information for the National Outcome Measures on readmissions to state psychiatric inpatient facilities with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Data was reported through the Uniform Reporting System (URS) tables. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other core indicators over the next three-year period. It should be noted that the current data system does not track individual youth across the community mental health and state hospital systems and although there is some overlap, data are likely to represent two different cohorts. For example, except for receiving a preadmission screening, not all youth served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Youth Court or Chancery Court systems. DMH continued work to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits and to have the capacity to track youth served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH and to improve data integrity. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

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

hospital and community services settings and increase focus on the provision of community-based services that prevent rehospitalization.

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

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

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

-(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	1.3%	.25%	.8%	.77%	.88%
Numerator: Number of civil readmissions to any state hospital within 30 days	5	1	3	3	3
Denominator: Total number of civil discharges in the year	375	402	375	387	341
2. Decreased Rate of Civil Readmissions to state hospitals within180 days	5.6%	5.47%	5.1%	5.6%	5.57%
Numerator:	21	22	19	22	19

Number of civil readmissions to any state hospital within 180 days					
Denominator: Total number of civil discharges in the year	375	402	375	387	341

Was objective achieved? The number of readmissions within 30 days remained constant between FY 2010 and FY 2011 at 3 youth. The number of discharges increased between FY 2010 and FY 2011. Although the percentage decreased by .01% from FY 2010 to FY 2011, the target of .77 was not achieved. Readmissions within 180 days remained the same from FY 2010 to FY 2011. The discharges decreased across these two years. The target for decreased readmissions within 180 days was achieved.

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

Sources of Information: Results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH) and case management service plans (reviewed by DMH Division of Children and Youth Services staff).

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

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

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

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding social connectedness	85%	87%	85%	85%	89%
Numerator: Number of families of children/adolescents reporting positively	259	646	459		474

about social connectedness					
Denominator: Total number of family responses regarding social connectedness	305	741	540		532

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 functioning on the *Youth Services Survey for Families (YSS-F)*

Sources of Information: Results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH).

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

results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 survey was 14%.

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

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

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding functioning	67%	70%	68%	68%	67%
Numerator: Number of families of children/adolescents reporting positively	203	520	366		359

about functioning					
Denominator: Total number of family responses regarding functioning	305	744	540		532

Was objective achieved? The percentage of families reporting positively about the functioning of their children/youth with serious emotional disturbances was slightly lower than targeted FY 2011 rates (67% versus 68%).

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

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

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

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

Population: Children with serious emotional disturbances

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

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

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

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

Special Issues: As mentioned in the specific objective on therapeutic foster care (described in the Plan), in accordance with federal URS table reporting instructions, the DMH is currently reporting the number of children receiving evidence-based practices in

programs receiving funding support from the public mental health agency. Additional youth receive services through therapeutic foster care programs certified, but not funded by the DMH. Youth also receive Multisystemic Therapy (MST) services through a nonprofit program that is certified, but not funded by the DMH and therefore, those data are not included in the EBP table above. DMH does not currently provide funding specifically for Family Functional Therapy; therefore, data is not available on the provision of FFT.

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

Action Plan: The objective to maintain therapeutic foster care services, the EBP that receives DMH funding support and described in the State Plan will be implemented. The Division of Children and Youth Services will also continue to provide technical assistance and to monitor therapeutic foster care programs certified, but not funded by the DMH. Initiatives to promote implementation of other evidence-based practices for youth and families, such as the Learning Collaboratives for trauma-focused cognitive behavior therapy described in the Plan will also continue. Other local initiatives will also continue; for example, Region 12 CMHC and Region 13 CMHC have organized workforce training in trauma-focused CBT, CBT and Combined Parent Child CBT for all of their children's therapists, and evidence-based practices for youth are being implemented through the local System of Care project in Region 12.

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 2011 State Plan (as described above), based on the final estimation methodology for children and adolescents with serious emotional disturbance published in the July 17, 1998 Federal Register.

Measure: Inclusion of prevalence estimates derived using federal methodology in the FY 2011 State Plan.

Comparison Narrative:

In the FY 2009 and FY 2010 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 2009 and FY 2010 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, 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 2008 is 378,753* Mississippi remains in the group of states with the highest poverty rate 32.6% 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 2009 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 41,663 – 49,238
(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 26,513 – 34,088

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 2010 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 (133,693**), yielding an estimated prevalence of 12,300 in this transition age group.

* Civilian population aged 9 to 17 were created by the NRI using Census data from 2008 for the numbers of persons aged 5 to 17 and aged 9 to 17. The percent of the 2008 data for aged 5 to 17 that was aged 9 to 17 was applied to the 2008 Census Civilian Population aged 5 to 17 to create the estimated 2008 aged 9 to 17 numbers

** Calculated by Dr. Barbara Logue, Senior Demographer, MS Institutions of Higher Learning, based on 2000 Census data and 2008 Census estimates.

In the FY 2011 State Plan, 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. Prevalence estimates were adjusted for socio-economic differences across states. Given Mississippi's relatively high poverty rate when compared to other states, the estimated prevalence ranges for the state (adjusted for poverty) were on the higher end of the ranges in the 7/17/98 Federal Register. The estimated number of children, ages 9 through 17 years in Mississippi in 2009 is 375,918* Mississippi remains in the group of states with the highest poverty rate (21.5% age 5-17 in poverty, based on 2008 Federal poverty rates), therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2010 are as follows:

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

As pointed out in the methodology, there are limitations to these estimated prevalence ranges, including the "modest" size of the studies from which these estimates were derived; variation in the population, instruments, methodology and diagnostic systems across the studies; inadequate data on which to base estimates of prevalence for children under nine; and, inadequate data from which to determine potential differences related to race or ethnicity or whether or not the youth lived in urban or rural areas. As noted in the discussion of the estimation methodology in the Federal Register, "(t)he group of technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that "(I)n the future, incidence and prevalence data will be collected." As explained in the section that follows on the population of children targeted in the FY 2011 Plan, the upper age limit in the definition for children with serious emotional disturbances was extended (beginning in the FY 2003 Plan) to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. The change in Mississippi's definition was made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. Although this constitutes a difference from the federal definition for children with serious emotional disturbance, which defines children as being up to 18 years, it is recognized in the 5/20/93 Federal Register that some states extend this age range as high as to persons less than age 22. In such cases, it was also noted in the Federal Register (5/20/93), that states should provide separate estimates for persons below age 18 and for persons aged 18 to 22. Since Mississippi has extended its age range for children with SED up to age 21 years, and kept its lower age range for adults with serious mental illness at 18 years, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (134,710**), yielding an estimated prevalence of 12,393 in this transition age group.

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

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

Source of Information: Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.

Special Issues: There are limitations to the interpretations of this prevalence estimate, explained above.

Significance: Estimates of prevalence are frequently requested and used as one benchmark of overall need and to evaluate the degree of availability and use of mental health services.

Funding: Federal and state funds

Was objective achieved? Yes

Quantitative Targets: Number of Children To Be Served

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

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

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

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

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

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

Special

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

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

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

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

National Outcome Measure: Increased Access to Services (Persons served in the public mental

health system under the age of 18 by gender, race/ethnicity) (Basic Tables 2A and 2B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
Total persons under 18 years served in public mental health system*	31,189*	31,821*	38,060	30,000	35,312

*****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**.**

Was objective achieved? Yes

Target or Priority Population to be Served Under the State Plan

Community-based Services for Youth with Serious Emotional Disturbances

Public community mental health services for children with serious emotional disturbance will be delivered through the 15 regional community mental health centers and through some other nonprofit community service providers. It should be noted that the number of youth targeted to be served in the following objective includes only youth with serious emotional disturbances served through the public community mental health system, which are a subset of the number of youth with any mental illness accessing services in the public community and inpatient system, reported in the previous NOM (URS Tables 2A and 2B).

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

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

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology
Brief Name: Total served in community mental health services

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

Measure: The count of the total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance (28,500)

PI Data Table C2.1	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# SED Served	29,269	30,199	31,488	28,500	32,629

Comparison Narrative:

In FY 2010, 30,767 children with SED were reported to have been served through the regional community mental health centers, and 721 children with SED were reported to have been served through other nonprofit providers certified and received funding from DMH; a total of 31,488 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 2011, 32,629 children with SED were reported to have been served through the regional community mental health centers, and 1,196 children with SED were reported to have been served through other nonprofit providers certified and received funding from DMH; a total of 33,825 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) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

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

Grant.

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

Was objective achieved? Yes

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 – "Think Again**"**

Indicator: To reach 200,000 individuals during FY 2011

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

MH Transformation PI Data Table	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Individuals reached by Anti-stigma campaign	1.3 million reached	200,000	1.5 Million	200,000	900,000

Comparison Narrative:

In FY 2010, DMH created an evaluation and developed a database to measure student's perceptions of mental illness prior to and after the anti-stigma presentations. A total of 1,979 evaluations were completed during FY 2010. According to the evaluations, prior to the presentation 48% of students had a positive or very positive view of mental illness and persons with mental illness. After the presentation, 69.7% of students had a positive or very positive view of mental illness and persons with mental illness. The evaluation also revealed that the media and personal experiences influenced students'

perceptions of mental health. A total of 81.3% of students reported that they could use information they learned during the presentation to help a friend in need.

In October 2009, DMH mailed more than 1,200 informational packets to 6th - 12th grade public school nurses and school counselors in Mississippi. The packets included a letter explaining the *Think Again* and *Shatter the Silence* campaigns and a brochure from each campaign. The letter also offered additional brochures to the schools and presentations to faculty and students.

DMH expanded its efforts to the faith-based community by hosting an event at First Baptist Church Gulfport in March 2010. The community event utilized the *Think Again* and *Shatter the Silence* campaigns to educate parents on mental health and youth suicide prevention.

By utilizing media coverage and presentations, the *Think Again* campaign reached an audience of 1.5 million.

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In FY 2011, a total of 238 presentations were conducted reaching more than 27,746 students, teachers and parents. A total of 3,124 presentation evaluations were completed in FY11. Based on the evaluations, prior to the presentation 23.2% of students had a negative view of mental health. After the presentation, only 7.2% of students had a negative view. Prior to the presentation, only 44.7% of students had a 14 positive perception of individuals with mental illness. After the presentation, 76.5% of students had a positive perception. Based on the presentation, 83.8% of students believed they learned how to help a friend in need. Students reported that the media influenced their views/perceptions of mental illness the most.

Central Mississippi Residential Center hosted its annual Mental Health Awareness Days for students. A total of 11 schools and 1,800 students participated in the event. Presentations were also conducted for 2,000 students at Natchez High School.

In October 2010, packets were developed which contained a sample Think Again/Shatter the Silence card, a Talk About It card, and a letter offering presentations, suicide prevention posters and additional materials. Packets were sent to more than 1,000 6th – 12th grade school nurses and counselors. The mailing addresses and labels were provided by the Department of Education's Office of Healthy Schools. As a result of the mail out, DMH received requests for more than 13,000 cards and posters.

DMH received cost quotes for the mental health awareness/suicide prevention Web site targeting teenagers. In May, surveys were distributed to teenagers to determine what information they would like to see on the Web site. Based on the survey results, copy for the Web site was completed in June. The goal is to have the Web site ready to launch in late August for the new school year. Information cards and posters promoting the Web site will be developed and provided to schools and colleges on the Gulf Coast

and then to other areas of the state.

DMH met with the Mississippi National Guard in July and August 2010 to develop an awareness campaign for the military that would consist of several components including a resource guide for accessing services, a stress/mental health brochure, and suicide prevention posters to hang in restrooms at units statewide. The campaign will target stigma and increase awareness about mental health and suicide prevention. A draft resource guide, poster and brochure were approved by the Joint Behavioral Task Force. The National Guard was provided with 15,000 brochures, 1,500 posters, 500 resource guides in September to begin distributing at units statewide with a letter from the General promoting suicide prevention and mental health awareness. The National Guard distributed the information to 12,000 army and 2,500 air members. Information was included in DMH's newsletter and the National Guard's newsletter. The campaign was also launched at Weems Community Mental Health Center's Mind Matters event for military and family members in Meridian on September 23, 2010. A letter was sent by the DMH Executive Director on September 13, 2010, to all CMHCs encouraging them to participate in the campaign and contact their local National Guard units.

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 2010, 434 resource directories were disseminated at conferences, meetings, or to individuals as follows: KIDS Count, Lafayette County MAP Team, MAP Team Coordinators, ISCC, MS Association of Pediatricians, Child Abuse Prevention Fair, Children's Mental Health Awareness Fair, Annual Lookin' To The Future Conference, Annual FASD Symposium, Gus McCoy (Youth Minister), State of Mississippi Attorney Generals Office, MS NAACP, Mississippi Families As Allies, Pre-Evaluation Screening Training, MS Families for Kids, School Nurse Orientation, Jackson Public Schools, and Catholic Charities Trauma Recovery for Youth Program. Presentations were made by the DMH Division of Children & Youth Staff at the following meetings/conferences/agencies:

Suicide Prevention for Teachers, Leland Public School District
FASD 101 and FASD Screening & Referral Trainings
Cultural Competency Workshops
Youth Suicide Prevention Workshop
MAP Team 101 Training
KIDS Count
Annual Alzheimer's Conference
Child Welfare Institute Conference
Leadership Jackson for Youth
Mississippi Coalition for Children's Welfare
Case Management Orientation (4)
MSFAA Respite Providers Training
Mississippi College School of Law Certified Juvenile Defenders Training
MS Mental Health Planning Council
Mississippi Annual American College of Obstetricians and Gynecologists Conference
DREAM
Community Mental Health Centers (Regions 2, 4, 6, 10, and 14)

Mississippi Department of Health
Joint MH/MR Conference
Annual Lookin' To The Future Conference
Juvenile Justice Mental Health Forum for Judges and Referees
Southern Christian Services for Children and Youth
MS Alliance for School Health Conference
Annual FASD Symposium

In FY 2011, 252 resource directories were disseminated at conferences, meetings, or to individuals as follows: Mississippi Families As Allies, Catholic Charities, Homeless Education Conference, School Health Advisory Council, Pre-Evaluation Screening Training, Division of Consumer and Family Affairs, and Tina Mann at Memorial Behavioral Health. Presentations were made by the DMH Division of Children & Youth Staff at the following meetings/conferences/agencies:

- FASD 101 and FASD Screening and Intervention Trainings for CMHCs and MAP Teams
- Cultural Competency Workshops Holly Springs School, Winston Choctaw Correctional Facility, and Lauderdale Law Enforcement
- MAP Team and A Team 101 Training
- KIDS Count
- Cultural Competency Training at Mississippi Youth Program Around the Clock (MYPAC) and MS FAA respite providers
- Case Management Orientation (2)
- FASD Education at the Pearl Local Children's Partnership and the MS Band of Choctaws
- National BFSS Conference
- Children's Mental Health Resources at Disability Rights Mississippi
- MS Mental Health Planning Council
- Community Mental Health Centers (Regions 2, 4,5,6,7,9,10,11,12,13,14, and 15)
- Annual Lookin' To The Future Conference
- Juvenile Justice Mental Health Forum for Judges and Referees
- Annual FASD Symposium
- WRAParound 101 Training for CMHC therapists

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, and 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 2010, informational materials and technical assistance were provided to 785 local schools by community mental health centers.

In FY 2011, informational materials and technical assistance were provided to 814 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 2011. 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 2011 will not be expended to provide any services other than in support of comprehensive community mental health services.

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 2011

Comparison Narrative:

In FY 2010, the DMH Executive Director continued to serve as the chair of the ICCCY, and the Dir. of DMH Children and Youth Services served as chair of the ISCC. The Center for MS Policy, the ICCCY, and the ISCC drafted legislation to expand membership, continue MS System of Care efforts, and to strengthen policies & procedures. House Bill 1529 was signed by the Governor in March 2010. The ISCC met on Nov. 16, 2009, to hear the recommendations from Mr. Cliff Davis (consultant) on the MS System of Care Assessment and Study. The ISCC met in April and June of 2010 to discuss the revisions of HB 1529 and implementation plans. Additionally, the ISCC met on September 21, 2010 to welcome the new members, to review the Bylaws and Interagency Agreement, and to develop a mission statement. The ICCCY met on Nov. 16, 2009, to hear the recommendations from the MS System of Care Assessment and Study, presented by Mr. Cliff Davis. The ICCCY also discussed next steps in drafting new legislation for 2010. The ICCCY also met on Dec. 11, 2009 via telephone conference to vote on the final recommendations of the Study to be included in the 2010 bill. The ICCCY met in June 2010 to make recommendations for new members, to begin revisions of the Bylaws and Interagency Agreement. Additionally, the ICCCY met on September 17, 2010 to welcome the new members, to review the System of Care legislation, to review an update on commUNITY cares, the mental health summit and to elect a new chairperson. The Executive Director of the Department of Human Services was elected chair.

In FY 2011, the Executive Director of the Department of Human Services served as the chair of the ICCCY, and the Director of Youth Services (DHS) served as the chair of the ISCC. The ICCCY met in January 2011 to receive an update on System of Care activities such as updates on commUNITY cares, Mississippi Transitional Outreach Program and MYPAC. The ICCCY also voted on revised Internal Organizational Procedures and MOU. The ICCCY met on May 11, 2011 to discuss updates on SOC projects and collaborative as well as make recommendations for a faculty/dean representative for the ICCCY. The ISCC met on January 5th, March 9th, May 4th, and August 3rd, 2011 to discuss projects, coordinate trainings/conferences, and discuss Cultural/Linguistic Competency, review data from MAP Team quarterly

reports, submit a SOC Planning Grant and to discuss sustainability of MYPAC and MTOP.

Source(s) of Information: Minutes of the ICCCY and the Division of Children and Youth Services Monthly Calendar and minutes of the mid-level Interagency System of Care Council and revised Interagency Agreement.

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

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

Funding: State and federal

Was objective achieved? Yes

State-Level Interagency 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 contract with a Licensed Clinical Social Worker for the facilitation and follow-up of cases reviewed. (Documentation of meetings maintained).

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

Comparison Narrative:

In FY 2010, the State Level Case Review Team reviewed 21 cases and also had 27 follow-up reviews on previously staffed cases. Of the new cases, four youth were diagnosed with and IDD and SED, one youth was diagnosed sexually reactive and three

were in the transitional age range. A meeting was held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

In FY 2011, the State Level Case Review Team reviewed 12 new cases and provided follow up on 20 cases. Of the new cases, 6 were diagnosed with a mood disorder, 2 were diagnosed with PTSD, 2 with ADHD, 1 with Bipolar Disorder and 1 with Intermittent Explosive Disorder. Six of the twelve were also diagnosed as Individuals with Developmental Disabilities. Six of the twelve were also diagnosed as Individuals with Developmental Disabilities. Ten of the youth were transitional age. The team meets on the second Thursday of each month to review new cases and/or follow-up on 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 2010, DMH continued to provide the State Level Interagency Case Review/MAP Team with funding to purchase critical services and/or supports identified as needed for 21 targeted children/youth with SED reviewed by the team.

In FY 2011, 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 21 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 2010, the Division of Children and Youth Services Director had coordinated five statewide meetings with the coordinators of local MAP Teams. The following items were discussed: Fetal Alcohol Spectrum Disorder screenings and trainings, ICCCY/ISCC activities, the MS System of Care Assessment and Study Report; MYPAC; case review; MAP Team expansion; transitional age youth; and juvenile justice. Technical assistance was provided to MAP Teams in CMHC Regions 2 and 6. A MAP Team 101 training was held April 15th for new MAP Team Coordinators in Regions 2, 5, 10, 11, and 14.

In FY 2011, the Division of Children and Youth Services Director had coordinated four statewide meetings with the coordinators of local MAP Teams. The following items were discussed: Fetal Alcohol Spectrum Disorders screenings, assessments and trainings; MYPAC updates; collaborative with Div. of Family & Children Services (DHS); MAP Team Expansion; MS Transitional Outreach Program; juvenile justice collaborations; Wraparound 101 and coaching trainings/process; flexible funds; Intellectual/Developmental Disabilities; NAMI and MS Families As Allies resources and programs. Technical assistance on expansion was provided to MAP Teams in CMHC Regions 2, 4, 10 and 11. A MAP Team 101 training was held March 30 for new MAP Team Coordinators in Regions 1, 5, 6, 10, 11 and all seven Coordinators of Adolescent "A" Teams operated by Department of Human Services.

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 38 teams)

PI Data Table C3.1	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# MAP Teams with Flexible Funding	16				
# MAP Teams with access to flexible funding		37	36	38	41

Comparison Narrative:

In FY 2010, one DMH certified provider in each of the 15 CMHC regions received a grant from DMH to provide flexible funds for MAP Teams. Forty–three counties either have a MAP Team or access to one and all 36 MAP teams continued to operate statewide and had accessibility to flexible funds. Region 8 continues to receive additional funding for children with fetal alcohol spectrum disorders.

In FY 2011, one DMH certified provider in each of the 15 CMHC regions received a grant from DMH to provide flexible funds for MAP teams. Fifty-four counties either have a MAP Team or access to one and all 41 MAP Teams continued to operate statewide and had accessibility to flexible funds. Region 8 continued to receive additional funding for children with Fetal Alcohol Spectrum Disorders.

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 2010, the DMH Children and Youth Services staff participated on the following interagency councils or committees:

- 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
- Drug Court Conference Committee
- American Pediatrics Ass. Mental Health Task Force
- Underage Drinking Task Force
- Prevent Child Abuse Advisory Council
- Multicultural Task Force
- Youth Suicide Prevention Advisory Council
- Dept. of Human Services Citizen's Review Board
- MS Alliance for School Health Conference Planning Committee
- commUNITY cares (SOC project) Core Committee, Sustainability Committee, and Cultural & Linguistic Committee
- MS Transitional Outreach Project (SOC project) Executive Council, Core Committee, Cultural & Linguistic Committee
- Juvenile Justice Mental Health Task Force

- Transitional Age Task Force
  Jackson Public Schools HS/SS Project

  In FY 2011, the DMH Children and Youth Services staff participated on the following interagency councils or committees:

- 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
- Drug Court Conference Committee
- Underage Drinking Task Force
- Multicultural Task Force
- Dept. of Human Services Citizen's Review Board
- commUNITY cares (SOC project) Core Committee, Sustainability Committee, and Cultural & Linguistic Committee
- MS Transitional Outreach Project (SOC project) Executive Council, Core Committee, Cultural & Linguistic Committee, and Social Marketing Committee
- Juvenile Justice Mental Health Task Force
- Transitional Age Task Force
- Mississippi Association of Addiction Professionals Conference Planning Committee
- Jackson State University SMHART Institute Conference Planning Committee
- Jackson Public Schools Healthy Schools/Safe Students Project
- Children's Trust Fund Advisory Council
- Mississippi Autism Advisory Council

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

Health and Mental Health Initiatives

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

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

Substance Abuse Initiatives

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

Social Services Initiatives

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

Specific social services are available to children with serious emotional disturbance administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The MDHS Division of Family and Children's Services provides child protective services, child abuse/neglect prevention, family preservation/support, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure and case management. The MDHS Division of Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program (TWP), Supplemental Nutrition Assistance Program (SNP), SNAP Nutrition Education and the "Just Wait" Abstinence Education program. The MDHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, A-Teams coordination, and oversees the state training schools. The MDHS Division of Child Support provides child support location and enforcement services, educational parenting programs, mediation, counseling programs, monitored and supervised visitations, and pro-se workshops and non-custodial visitation programs. The MDHS

Office for Children and Youth provides certificates for child care services for TANF and Transitional Child Care (TCC) clients, children in protective services or foster care, as well as low income eligible working parent(s) or parent(s) in an approved full-time education or training program. The MDHS Division of Aging and Adult Services provides resources to the elderly and disabled population through the system of Area Agencies on Aging. The ADRC/Mississippi Get Help provides a website for services and resources available throughout the state. One phone call provides access to trained Information and Assistance Specialists, who help with referrals to agencies and/or services, eligibility information, application assistance to apply for services, long-term care options counseling and follow-up.. The MDHS Division of Community Services provides services such as homeless resource referrals low income utility assistance, weatherization of eligible clients' homes and the Fatherhood Initiative Program. Through Community Services Block Grant (CSBG), the Division of Community Services offers health and nutrition programs, transportation assistance, education assistance, income management, housing and employment assistance.

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

A free appropriate public education (FAPE) must be available to all children residing in the **S**tate between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP).

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

After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment. Those services could include a functional behavioral assessment, behavioral intervention plan, and other positive behavioral interventions and supports determined by the IEP Committee. Each district must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities who reside within their jurisdiction for the provision of special education and related services. It is the IEP Committee that determines the appropriate special education and related services (including transition services) and placement of student with disabilities.

Any related service required by a student to enable him or her to benefit from their special education services and any transition services determined appropriate by the IEP Committee must be provided at no cost to the parent. These related services include, but are not limited to: communication services, counseling services, physical therapy, occupational therapy, behavior interventions, assistive

technology evaluations and devices, parent education and training, adapted physical education and transportation. All districts in the State must provide all services as determined by the IEP Committee.

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

Other Educational Services and Initiatives

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

MDE has implemented a system of focused monitoring that uses continuous review and utilization of data to ensure improvement. Annual data profiles are provided to districts and to the public, and Local Education Agencies are ranked on the priority indicators to identify districts for focused monitoring and those in need of improvement. One of the priority indicators is identification of children with emotional disabilities. All districts must conduct an annual self-review by analyzing data, reviewing records and developing improvement plans that address issues identified in the self-review. Districts in need of improvement must submit improvement plans. Those receiving focused monitoring visits must submit improvement plans that address each identified area of noncompliance. Follow up visits are conducted to ensure implementation of corrective actions. Focused monitoring includes predictable sanctions and rewards to ensure that all districts are improving. Based on data from MDE, the number of children with emotional disabilities identified in the schools has increased for the last five school years.

As mentioned under Criterion 1, the Division of Children and Youth Services targets many of its outreach efforts to school settings through provision of educational materials and presentations. A major area of growth in the system of care has been the development through community mental health centers of school-based outpatient sites and day treatment statewide, which is also the primary strategy for increasing accessibility of services for youth in rural areas. Objectives related to expanding school-based community mental health services are located under Criterion 1 and Criterion

4. Representatives of the MDE are participants in state-level interagency groups described previously in this section, and local school district representatives are participants on local Making a Plan teams. Community mental health centers also provide training on children's mental health services to local teachers.

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

Sources of Information: Uniform Reporting System (URS) data from Table 19B, which are based on results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH) and interagency agreements between schools and CMHCs providing school-based services.

Special Issues: In addition to the data being based on self-report, the relatively low number of total responses to this survey item compared to the number of responses to other items on the survey, and the relatively high number of "not applicable/no responses (273 in 2009) excluded from the total responses to this item in calculating percentage of improvement should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of "branching" questions added to the end of the original *YSS-S* survey instrument to gather information on this NOM), which may be confusing to some respondents.

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

facilitate attendance through therapy and consultation services provided to the child, family and the school.

Action Plan: School-based therapists employed by the CMHCs will continue to offer and provide as requested mental health services in the local schools, including school-based outpatient and school-based day treatment programs as described in the State Plan. The provision of school-based mental health services is projected to facilitate access to community mental health services, especially in rural areas and to positively impact school attendance by those children and families served by CMHCs.

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

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% age of Families of children/adolescents reporting improvement in child's school attendance	44.3%	41%	53%	44%	33%
Numerator: Number of families of children/adolescents reporting improvement in child's school attendance (both new and continuing clients)	78	158	142		120
Denominator: Total number (including Not Available) (new and continuing clients combined)	176	385	267		362

Was objective achieved? No. There was an error in calculating the percentage for the number of families reporting improvement in their child's school attendance for FY 2010. This error has been corrected and is noted in the table. For FY 2011, the percentage targeted of families reporting an improvement in their child's school attendance was lower (33% versus 44%) than the targeted

percentage rate.

Mental Health Transformation Activities: Juvenile Justice Initiatives

Adolescent Offender Programs

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

Juvenile Justice Interagency Training

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

Indicator: Increase in the percentage of parents/caregivers of children/adolescents served by the public community mental health system reporting that their child had been arrested in one year, but was not rearrested in the next year

Measure: Percentage of children/adolescents served by the public community mental health system reported by parents/caregivers as arrested in Year 1 (T1) who were not rearrested in Year 2 (T1**)**

Sources of Information: Uniform Reporting System (URS) data from Table 19A, which are based on results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system (funded and certified by DMH), certification reports and Division of Children & Youth Services Monthly activity log (for technical assistance).

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

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

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

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

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% age of children/adolescents Arrested in Year 1 (T1) who were not	33%	50%	73%	44%	42.4%

rearrested in Year 2 (T2)					
Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	4	14	11		14
Denominator: Total number of children/adolescents arrested in T1 (new and continuing clients combined)	12	28	15		33

Was objective achieved? No. The percentage of youth arrested in Year 1 who were not rearrested in Year 2 was lower than projected for FY 2011 (42.4% vs 44%).

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 2010, the Transitional Advisory Council (formerly the Transitional Task Force) met in November 2009, April 2010, and July 2010 to develop strategies related to increasing appropriate service options. The following topics were discussed:

- Education on Rise Above for Youth Program
- SOC grant award for transition age youth called MS TOP
- Change of the Transitional Task Force to the Transitional Advisory Council
- Development of goals and a mission statement for the Council
- Updates from state agencies
- Involvement of more youth and families on the Task Force
- RFP process and for the SOC grant
- Award recipients of MS TOP SOC grant
- Housing and homeless transition age youth
- Conferences with sessions directly related to transition age youth
- Updates on the MS TOP SOC grant
- DHS custody issues and transition age youth
- Updates on cultural and linguistic issues
- Education on P.A.L.S. and the Host Homes Program
- Employment and jobs skills training
- Helping schools become culturally competent

In FY 2011, the Transitional Advisory Council met in December 2010 to develop strategies related to increasing appropriate service options. The following topics were discussed:

- Update on the MTOP Grant Project
- Update on the DHS Independent Living Program
- Case Presentation by Mississippi Children's Homes Services
- Update on PTOP Program operated by Region 12
- Update on the MS JAG Grant

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 Program

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

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**s** and two supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.

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

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

Comparison Narrative:

In FY 2010, 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); four of the homes received DMH funding support.

In FY 2011, 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); four 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

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

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

Criterion: Targeted Services to Homeless and Rural Populations

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

Indicator: Continued funding to a Women's Center for Nonviolence to be made available for crisis intervention services to children and families in a domestic violence situation.

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

PI Data Table C4.2	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Children in Domestic Violence Situation Served	74	71	100 125 children served; 3 with SED	100	106 children served; 1 with SED

Comparison Narrative:

In FY 2010, Gulf Coast Women Center served 125 youth, three 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**.**

In FY 2011, Gulf Coast Women Center served 106 youth, one of whom was a child 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 (200)

PI Data Table C4.3	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Abused/ Neglected Children Served	353	294	293	200	283

Comparison Narrative:

In FY 2010, 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 293 children in FY 2010; all children were enrolled in the services at Region 13 and had a serious emotional disturbance.

In FY 2011, 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 283 children in FY 2011; 36 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 at the shelter are also provided training by the CMHC in crisis intervention techniques, behavior modification, communication issues, children's reaction to abuse and neglect, and recognizing indicators of sexual abuse. The shelter serves children who have allegedly experienced abuse and/or neglect.

Funding: Federal

Was objective achieved? Yes

Therapeutic Group Homes and Therapeutic Foster Care Services

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

Coordination with Other Agencies

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 2010, CYS staff made two technical assistance visits and conducted a certification review of Catholic Charities Host Homes Programs. Certification began March 1, 2010. All therapeutic group home providers received training and technical assistance on regulations, schedules, staff requirements, supervision of youth and criteria for admission.

In FY 2011, CYS staff continued to provide technical assistance to certified Therapeutic Foster Care, Therapeutic Group Homes, MAP Teams and the Mississippi Transitional Outreach Program on finding and utilizing community resources for homeless/runaway youth. MAP Team Coordinators attended five state-wide meetings facilitated by the Division Director in which topics such as housing, utility and rent assistance were discussed. The Mississippi Transitional Outreach Program (MTOP) began providing services on February 1, 2011 in both CMHC Regions 4 & 7. MTOP provided supervised living arrangements for those transition-aged youth, between ages 16-21 who were homeless, runaway or at-risk of becoming homeless. DMH staff provided training and technical assistance on the revised Operational Standards for Community Mental Health Programs in November and December 2010.

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

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

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
# Providers Receiving T.A. /certification visits	10	15	15	15	15

Comparison Narrative:

In FY 2010, 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 2011, 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 2011, 15 CMHCs and 6 other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; 12 CMHCs and 2 other nonprofit programs reported making transportation available through affiliation agreement with other agencies; and, 10 CMHCs and 2 other nonprofit programs reported utilizing local public transportation (buses, cabs, 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 2011)**

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 2012 budget request for community support services for children with serious emotional disturbances.

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

Comparison Narrative:

In FY 2010, DMH requested $30,400,000 for full funding of Medicaid match for the CMHC program in its budget request for the fiscal year that began July 1, 2010; about 45% of these funds address children's services, and the remainder addresses adult services. No additional funding was appropriated to DMH for the matching funds or any other purpose. CMHC match for FY 2011 will be paid one-half from DMH funds by using money from facility special fund cash balances; the other half will be contributed by the CMHCs.

During the 2011 legislative session, for the fiscal year that began July 1, 2011, and ends June 30, 2012, DMH requested $1,803,000 general funds to replace the loss of an equal amount of federal funds under enhanced Federal share of Medicaid for residential programs operated by DMH facilities. DMH requested $20,000,000 for the state's one-half share of Medicaid match on payments received by the fifteen regional community mental health centers (with the CMHC's paying the other half). In addition , DMH requested $7,116,000 to restore funding to community

based programs that were cut due to diverting funds to Medicaid match for a Home and Community Based Waiver Program for persons with IDD ($1,550,000), a loss of federal Social Services Block Grant funds ($3,366,000), and a loss of state source funds due to budgetary issues ($2,200,000). Approximately 50% ($3,558,000) of the amount requested to be restored is for community mental health programs with the remainder being for substance abuse services and services to persons with intellectual and developmental disabilities. DMH requested a total increase of $25,361,000 for mental health services.

The legislature granted $1,803,000 to replace loss of enhanced federal share of Medicaid and $17,166,000 (of $20,000,000 requested, or about 86%) for the state's one-half share of Medicaid match on Medicaid payments to the fifteen regional CMHC's. (These figures exclude amounts requested and received for substance abuse services and services to persons with intellectual and developmental disabilities.)

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

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

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

Funding: State

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 2010, Division of Children and Youth staff provided and/or facilitated the following training for providers of mental health services for children/youth:

October 2009: Provided cultural competency & diversity; MAP Team training; Suicide Prevention for one public school district; and FASD screening and basics.

November 2009: Cultural Competency and Mental Illness; FASD 101, screening, referrals, and assessments; and, Youth Suicide Prevention for local churches.

December 2009: FASD Basics and screening for case managers at CMHCs;

January 2010: Wrap around for CMHCs Children's Coordinators: Children's System of Care initiatives for a conference; MAP Team Introduction for a local MAP team; therapeutic group home collaboration and regulations for providers; and, FASD basics and screening for case managers at the CMHCs.

February 2010: Case Management Orientation; youth suicide prevention for social workers; and, FASD training for mental health providers.

March 2010: Children's system of care initiatives; FASD Basics for CMHCs; and, Case Management Orientation.

April 2010: Wrap around 101 for mental health providers; juvenile mental health issues for public defenders; MAP Team 101, expansion, and development; and, FASD basics for Headstart providers.

May 2010: Children's mental health awareness; Wrap around 101 training for CMHCs; and, Case Management Orientation.

June 2010: MAP Team 101 for social workers; cultural diversity for CMHC; juvenile mental health

issues;

July 2010: MAP team basics and development; cultural diversity for CMHC; and, children's mental health services to Planning Council members.

August 2010: MAP Team development and expansion for CMHCs; MYPAC services and collaboration for CMHCs;

September 2010: cultural and linguistic competency training for CMHCs, juvenile mental health issues for youth court judges, MAP Team development; FASD Symposium; Case Management Orientation; System of Care principles and values for two CMHC; and, System of Care development for two CMHCs.

In FY 2011, Division of Children and Youth staff provided and/or facilitated the following training for providers of mental health services for children/youth:

October 2010: Case Management Orientation, ASIST Training, Day of Diversity and Cultural Competency, FASD Introductory Training, and FASD Intervention Training

November 2010: DMH Operational Standards Training for Central Office, Rural Mental Health for Students and Families who are Homeless, and Cultural Competency Training

December 2010: DMH Operational Standards Training for CMHCs and non-profit providers, and FASD Introductory Training

January 2011: WRAParound 101 Training

February 2011: Cultural Competency: What You Need to Know for Holly Springs School, FASD Intervention Follow-Up Training for CMHCs, and FASD Screening Training

March 2011: Cultural Competency: What You Need to Know for Lauderdale Law Enforcement, MAP and A Team 101 Training, FASD Photographic Software Training for Region 15, FASD for MAP Teams, and Case Management Orientation

April 2011: Cultural Competency Training for MYPAC and MSFAA respite providers, MAP Team and JAG Grant presentation at the MS State Mental Health Planning and Advisory Council Meeting, and FASD and Prepare/Skill Streaming Training

May 2011: Cultural Competency: What You Need to Know for MS Association of Drug Court Professionals, Sustaining FASD and the System of Care at the 2011 National BFSS Conference, Connecting the Dots for Children's Services at the 2011 National BFSS Conference

June 2011: Cultural Competency: What You Need to Know for the Board of Examiners for Social Workers, WRAParound 101 Training, MAP Teams at the Annual Lookin' To The Future Conference, and FASD in Mississippi at the Annual Lookin' To The Future Conference

July 2011: NCBI Training for Winston County Choctaw Correctional Facility, Connecting the Dots for Children's Services FASD Training for Regions 12 and 15, and Children's Mental Health Resources for Disability Rights Mississippi

August 2011: FASD: What Everyone Needs to Know for MS Band of Choctaws, and FASD Connect the Dots for Children's Services for Regions 2,4,5,6,7,9,10,11,13 and 14

September 2011: 8th Annual FASD Symposium: It's Preventable Ya'll; FASD: What Everyone Needs to Know for the Pearl Local Children's Partnership

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 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)

# Attendance at Statewide Institute or DMH-sponsored conference	885				
# of statewide conferences and/or training sessions sponsored or co-sponsored by DMH CYS		Four	Five	Four	Five

Comparison Narrative:

In FY 2010, DMH continued to serve as a primary sponsor of the Annual Lookin'to the Future Conference conducted by Southern Christian Services. DMH also sponsored the Annual KIDS COUNT Conference and four WRAP Around trainings held by the University of Maryland. DMH continued to sponsor the annual Mississippi Alliance for School Health Conference in September 2010. Additionally, DMH will continue to sponsor the Annual FASD Symposium in September 2010.

In FY 2011, DMH continued to serve as a primary sponsor of the Annual Lookin' to the Future Conference conducted by Southern Christian Services. DMH also sponsored three WRAP Around trainings held by the University of Maryland; an Applied Suicide Intervention Skills Training (A.S.I.S.T.); Juvenile Justice Symposium; and the Annual FASD Symposium in September 2011.

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 (50)

Mental Health Transformation PI Data Table	**FY 2008 (Actual)**	**FY 2009 (Actual)**	**FY 2010 (Actual)**	**FY 2011 (Target)**	**FY 2011 (Actual)**
# Additional community mental health services staff trained in TF-CBT	83 Baseline	78	~~65~~ **73**	50	61 (34 additional clinicians completing training by November 2011**)**

Comparison Narrative:

In FY 2010, the Mississippi Trauma Recovery for Youth (TRY) Project began a Learning Collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) in January 2010 with four CMHC regions and staff from Specialized Treatment Facility. This Collaborative was attended by 28 therapists and clinicians. 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. In the summer 2010, 45 clinicians at Pine Belt Mental Healthcare Resources were trained in TF-CBT.

In FY 2011, the Trauma Recovery for Youth Project (TRY) at Catholic Charities, Inc. of Jackson, MS worked to further spread Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) through a Learning Collaborative, training 22 clinicians at Region 4 and 7 CMHCs. Also, TRY provided SPARCS training for new clinicians at CMHCs that had previously completed a SPARCS Learning Collaborative. This Learning Community trained 28 clinicians at Regions 3, 4, 7, 10, 12, 15, and Specialized Treatment Facility. TRY also completed TF-CBT trainings for Region 12 (training 51 clinicians) and Region 11 (training 10 clinicians). Finally, TRY began TF-CBT training for Regions 4 and 7 in September 2011. This will conclude in November with 34 additional clinicians trained in 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

In FY 2011, three case management orientation sessions had been conducted and 78 case managers were trained. Training and technical assistance for new case managers, as well as review sessions for existing case management staff, continue to be available from DMH Division of Children and Youth staff, upon request from CMHCs. Technical assistance, orientation and support for case managers are available at the local level through existing staff at the CMHCs. The case management training program is currently available online and provides cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area.

Mental Health Therapist Program
Licensed Department of Mental Health (DMH) Administrator Program
Case Management Professional Program

Objective: To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Licensed DMH Administrator and Case Management Professional Credentialing Programs.

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems

Brief Name: Number of DMH credentialed staff

Indicator: The number of individuals who hold a credential in the Mental Health Therapist program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE); the number of Program Participants and those holding licensure in the Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.

Measure: The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees who hold a credential in the Licensed DMH Administrator Program; the number of individuals who hold a credential in the Case Management Professional Program (Note: This measure does not include individuals whose credentials have lapsed/expired.)

Comparison Narrative:

In FY 2010, a total of 158 Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional (CCMP-I) or Certified Case Management Professional-II (CCMP-II) credentials were awarded.

A total of 86 individuals currently hold the Licensed DMH Administrator credential, and a total of 14 individuals are currently Participants in the Licensed DMH Administrator credentialing program. In FY 2010, three individuals entered the Licensed DMH Administrator Program, and six Licensed DMH Administrator credentials were awarded. Each Participant continues to receive training in the area of administration through his/her participation in the Mississippi Certified Public Manager Program and his/her preparation for the required written examinations or his/her participation in DMH's leadership development program, Focus.

In FY 2011, a total of 774 individuals held a case management credential as a Provisionally Certified Case Management Professional (PCCMP) or Certified Case

Management Professional (CCMP).

A total of 100 individuals held the Licensed DMH Administrator credential or participated in the Licensed DMH Administrator credentialing program.

In FY 2011, a total of 1,211 individuals held a credential in the Mental Health Therapist Program.

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, however, the number of individuals holding a credential in the Mental Health Therapist Program for FY 2011 is slightly lower than projected due to stagnant hiring patterns among our DMH certified programs in response to the struggling economy.

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

Credentialing Program	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Actual)	FY 2011 (Target)	FY 2011 (Actual)
Mental Health Therapists (all levels)	1,959	2,161	2,237		
Mental Health Administrators (all levels)	122	126	127		
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	_	-		_	

Number of individuals in the Case Management Certification Program (Beginning FY 2006)	629/758	607	844		
Number of individuals who hold a credential in the Mental Health Therapist Program				1,275	1,211
Number of individuals how are Participants or who hold a credential in the Licensed DMH Administrator Program				97	100
Number of individuals who hold a credential in the Case Management Professional Program				100	774

Mental Health Transformation Activity: Workforce Development through Academic Linkages

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

Telepsychiatry Project

The UMMC Department of Psychiatry and Human Behavior received a grant from the Delta Health Alliance and began implementing a telepsychiatry service with two sites in the Delta region in FY 2009. They initiated services in early August 2008 for two community mental health centers (in Greenwood and in Clarksdale) The telepsychiatry project received additional funding from the Delta Health Alliance during FY 2010 to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff; they expect to have all community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service linked with the telepsychiatry unit based at MS State Hospital to provide continuity of care for those individuals admitted to the MS State Hospital from the designated Delta community mental health centers. The Department of Psychiatry will also use the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). In addition, the Department of Psychiatry is looking into ways of

sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

Information Management Systems Development

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

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

Population: Children with Serious Emotional Disturbance

Criterion: Management Systems

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

Indicators/Strategies:

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

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

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

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

Measure: Progress on tasks specified in the Indicator.

Comparison Narrative:

In FY 2010, 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 needed 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. All fifteen regional community mental health centers and 3 out of 4 of the state psychiatric hospitals are presently submitting data that populates the database.

The 13 Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are-working on 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.

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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

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

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

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

Providers	**Projected Allocation**
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley Interim Executive Director (MAP Team flexible funds)	$15,357
Communicare 152 Highway 7 South Oxford, Mississippi 38655 Carole B. Haney, Acting Executive Director (MAP Team flexible funds)	8,000
Region III Mental Health Center 2434 S. Eason Blvd. Tupelo, MS 38801 Robert J. Smith, Executive Director (Intensive Crisis Intervention; MAP Team flexible funds)	38,565
Timber Hills Mental Health Services P. O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Executive Director (Therapeutic Nursing Services, MAP Team flexible funds, and new Comprehensive Crisis Service Array)	168,677
Delta Community Mental Health Services 1654 East Union St. Greenville, MS 38704 Richard Duggin, Executive Director (MAP Team flexible funds)	10,000
Life Help P.O. Box 1505 Greenwood, MS 38935 Madolyn Smith, Executive Director (MAP Team flexible funds)	17,857

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

flexible funding)

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

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

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

Gulf Coast Women's Center 30,000
P. O. Box 333
Biloxi, MS 39533
Sandra Morrison, Director
(Intensive Crisis Intervention)

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

MS Families As Allies for Children's Mental Health, Inc. 221,040
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)

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 P. O. Box 64 Vicksburg, MS 39180 Kay Lee, Director (Sexual Abuse Intervention)	25,039
Department of Mental Health 1101 Robert E. Lee Building 239 North Lamar St. Jackson, MS 39201 Edwin C. LeGrand III, Executive Director (Funds to support peer monitoring, and and training, which may be granted to local entities for implementation)	17,424 5,000
TOTAL	**$1,549,296**

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

b) FY 2011 STATE PLAN IMPLEMENTATION REPORT 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 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). \`Q123

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation of peer review

Indicator: A Recovery Self Assessment (Assessment) tool developed to measure transformation from a traditional mental health service system to a recovery-oriented system of care. The primary goal of the Assessment is to provide a tool that assists stakeholders to consistently track transformation activities in accordance with the Department of Mental Health's vision of developing a person driven, recovery oriented system of care.

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

Comparison/Narrative:

In FY 2010, the Peer Review Manual was updated, and is awaiting the DMH Standards revision and approval of selected recovery components to be incorporated into the peer

review process. The Recovery/Resiliency Self Assessment tool was developed and is being reviewed by selected CMHC staff, consumers, family members, and interested stakeholders for feedback. The Recovery/Resiliency Self Assessment will be incorporated into the DMH Standards across all Bureaus to evaluate CMHCs, State hospitals and non-profit services/programs during the site visit process.

In FY 2011, DMH revised its operational standards, effective January 2011. The 2011 Operational Standards require that all DMH Certified Providers complete a self assessment during their 3 year certification period. DMH is completing its 1st year of Certification. Prior to the requirement of the assessment, DMH has been providing technical assistance and education to certified providers to orient them to concepts of recovery and resiliency and DMH person centered principles.

Source(s) of Information: Peer review reports, which are mailed to the Community Mental Health Centers and the Division of Community Services at East MS State Hospital and MS State Hospital.

Special Issues: Peer monitors include family members, consumers and/or professional staff. Typically, peer review teams conduct visits in conjunction with DMH standards monitoring visits. The number of peer review visits conducted within a given time period can vary, which is related to variations in the certification visit schedule. The teams will conduct an assessment with the programs utilizing the Recovery Self Assessment guide after a self assessment has been completed by the community mental health center, state hospital, and/or private program.

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Peer review site visits provide additional technical assistance opportunities for community programs from other providers in the state on a regular basis. The Recovery Self Assessment tools will allow the Department of Mental Health to assess how the community mental health centers and state hospitals identify strengths that already exist and acknowledge areas that require enhancement and further development..

Funding: CMHS Block Grant Funds

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 2010 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region beginning with the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions.

Significance: Improving the outcomes of services from the perspective of individuals receiving services is a key indicator in assessing progress on other goals designed to support recovery-oriented systems change.

Action Plan: The Division of Community Services and the Division of Family and Consumer affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care and dissemination of evidence-based practices, e.g., continued availability of training on person-centered planning, development of an education campaign about recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change, and the initiative to provide training on evidence-based, integrated treatment for persons with co-occurring disorders.

Satisfaction Survey of Individuals Receiving Services

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% Reporting Positively about Outcomes	71%	74%	70.5%	72.5%	56%
Numerator	447 Positive responses	1071 positive responses	909 positive responses		557 positive responses
Denominator	690 response	1453 responses	1289 responses		998 responses

* As recommended by CMHS, starting in FY 2006, the official version of the MHSIP survey is being used. The FY 2006 MHSIP and subsequent surveys also included additional items recommended by CMHS, which may also affect response rates; therefore, a new baseline was established.

Results from the *MHSIP Consumer Satisfaction Survey* indicate perception of care in all major domains of service, in addition to the National Outcome Measure on outcomes of services (described above). These domains include outcomes, access, quality and appropriateness, participation in treatment planning and general satisfaction with services and are indicated in the following table.

Satisfaction Survey of Individuals Receiving Services
National Outcome Measure: Client Perception of Care – Outcomes (URS Basic Table 11)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
1. % Reporting Positively about Access	89%	89%	88.5%	89%	81%
Numerator	564 positive Responses	1332 positive responses	1,157 positive responses		828 positive
Denominator	636 responses	1494 responses	1,307 responses		1,018 responses
2. % Reporting					

Positively about Quality and Appropriateness for Adults	90%	91%	88.5%	90%	79%
Numerator	569 positive Responses	1351 positive responses	1,155 positive responses		797 positive Responses
Denominator	635 responses	1491 responses	1,305 responses		1,012 responses
3. % Reporting Positively about Outcomes	71%	74%	70.5 %	72.5%	56%
Numerator	447 positive responses	1071 positive responses	909 positive responses		557 positive responses
Denominator	628 Responses	1453 responses	1,289 responses		998 responses
4. % Reporting on Participation in Treatment Planning	76%	80%	79%	77%	88%
Numerator	480 positive responses	1158 positive responses	990 positive responses		890 positive responses
Denominator	631 responses	1451 responses	1,256 responses		1,016 responses
5. % Reporting Positively about General Satisfaction with Services	90%	91%	90%	91%	89%
Numerator	574 positive responses	1366 positive responses	1,169 positive responses		907 positive Responses
Denominator	637 responses	1493 responses	1,303 responses		1,015 responses

Was objective achieved? The objective was not achieved. The FY 2011 target for the NOM on outcomes was not met, and was less than the percentages reported for the previous two years. Although the reasons for the decrease in positive responses in the outcome domain are not readily apparent from this data, activities to improve perception of outcomes by consumers will continue as described in the FY 2012 State Plan. The target was exceeded in FY 2011 on the domain for participation in treatment planning and the target for reporting positively about general satisfaction with services was slightly below (2%) the projection for FY 2011.

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 2010, 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. OCS also provides all DMH bureau directors with quarterly informal and formal grievance reports indicating follow up and resolution of all complaints and grievances. OCS continues to update the statewide database used for information and referral. Approximately 60 new programs were added and over 500 individual program's information was updated in the reporting period. This process is ongoing. OCS contracted with the National Suicide Prevention Lifeline in December 2008 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 the beginning of FY 2010, OCS has received 7622 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. In January 2010, OCS contracted and developed the capacity to offer individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. OCS is also able to capture data and analyze trends related to the needs expressed by individuals. Since the inception of the program, there have been 189 messages sent and received, 1618 log-ins to the system and 122 individual user accounts created. Data from this program is included in the quarterly reports.

In FY 2011, 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. OCS also provides all DMH bureau directors with quarterly informal and formal grievance reports indicating follow up and resolution of all complaints and grievances. OCS continues to update the statewide database used for information and referral. Approximately 60 new programs were added and over 500 individual's program information was updated in the reporting period. This process is ongoing. OCS contracted with the National Suicide Prevention Lifeline in December 2008 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 the beginning of FY 2011, OCS has received 7622 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. In January 2010, OCS contracted and developed the capacity to offer individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. OCS is also able to capture data and analyze trends related to the needs expressed by individuals. Since the inception of the program, there have been 189 messages sent and received, 1618 log-ins to the system and 122 individual user accounts created. Data from this program is 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 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 2011 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council, and the number of new members from other ethnic groups added to the Task Force.

Comparison/Narrative: In FY 2010, the Multicultural Task Force met on November 23, 2009, April 16, 2010, June 24, 2010, and August 19, 2010. The task force organized the statewide Day of Diversity that was held on October 13, 2009. The annual report to the Planning Council was presented by the Co-Chair of the task force on April 22, 2010. On September 1-2, 2010, several task force members attended the "Building a Community of Diversity: Understanding Cultural Competency workshop". The workshop was a collaboration between the Department of Mental Health, MTOP and commUNITY cares. The presenters were Dr. Ken Martinez, lead for the Technical Assistance Partnership's Cultural Competence Action Team and Holiday Simmons, community educator in the Southern Regional Office of Lambda Legal. The co-chair was one of the organizers of the workshop. On September 22, 2010, the co-chair of the Multicultural Task Force presented at the 2010 Rural Behavioral in Glendale, Arizona, with Dr. Vivian Jackson on "Disparities within Disparities: A Look at the 5 A's Through the Eyes of Persons of African Heritage in Rural America."

In FY 2011, the Multicultural Task Force met on December 3, 2010, March 25, 2011, May 20, 2011 and August 19, 2011. The task force organized the statewide Day of Diversity which occurred on October 13, 2010. The annual report, presented by a task force member to the Planning Council, was presented on August 13, 2011. The task force members received updates on the Mississippi Transitional Outreach Project (MTOP), Cultural Competency Plan, and Strategic Plan. The task force also discussed implementing a language access plan. Task force members attended the "Building a Community of Diversity: Understanding Cultural Competence, Part II conference on

September 22 – 23, 2011. The co-chair of the task force served as a presenter and organizer for the conference. The conference was a collaboration between the Department of Mental Health and commUNITYcares. The co-chair also served on the conference committee for the "Innovative Mental Health Services: Building Relationships and Strengthening Diverse Communities." This conference was a partnership with Southern Institute for Mental Health Advocacy, Research and Training (SMHART) Jackson State University, and Latasha Norman Center for Counseling and Psychological Services.

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

Cultural Competency Plan

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation Cultural Competency Workgroup

Indicator: Meeting/activity by the Cultural Competency Workgroup

Measure: The development of the committee and number of meetings

Comparison/Narrative: In FY 2010, on March 31, 2010, Region 2 completed the local cultural

competency assessment. The results of the assessment were discussed with the Clinical Director on September 30, 2010. The Clinical Director requested recommendations to address areas of concern and cultural competency training.

In FY 2011, the Department of Mental Health Cultural Competence Implementation Workgroup was established. The workgroup consists of: individuals receiving services, DMH/Division of Adult Services, DMH/Division of Children Services, DMH/Division of IT, DMH/Bureau of Alcohol and Drug Services, DMH/Bureau of IDD and DMH/Division of Prevention Services. The committee met three times this year. The committee has updated the Cultural Competency Action Plans and made changes to the Cultural Competency Implementation Workgroup Strategic Plan. The workgroup has completed several targeted strategies/activities related to the plan. In addition, the workgroup recommended standards for the DMH Operational Standards related to linguistic competency. These recommendations are now included in the DMH Operational Standards. The workgroup also made recommendations to include specific data collection questions in DRA to capture additional data related to cultural competency.

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

Special Issues: None

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

Funding: State Funds

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 2010, on March 31, 2010, Region 2 completed the local cultural competency assessment. The results of the assessment were discussed with the Clinical Director on September 30, 2010. The Clinical Director requested recommendations to address areas of concern and cultural competency training.

In FY 2011, Weems Mental Health Center agreed to participate in the cultural competency assessment project. The meeting was held with the Executive Director and a staff member on May 3, 2011. The assessment was administered on May 26, 2011 to staff who represent the different service areas that are provided by Weems Mental Health. The mental health center received the results on October 20, 2011 during meeting with the Executive Director and a staff member. The Executive Director provided a list of actions that will be taken regarding the results of the assessment on October 24, 2011.

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 service providers (Minimum

of 3)

PI Data Table A1.4	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# of NCBI Training Sessions for service providers	4	6	5	3	9

Comparison/Narrative: In FY 2010, NCBI training sessions were conducted with MS Families As for Children's Mental Health, Inc. on April 23, 2010, Timber Hills Mental Health Services (Region 4 CMHC) on June 11, 2010, Singing River Services (Region 14 CMHC) on July 29 and 30 (two separate trainings) and Communicare (Region 2 CMHC) on August 25, 2010. The trainings included adult services providers. Adult service providers had the opportunity to participate in their local CMHC Day of Diversity activities in Oct. 2009. The co-chair of the Multicultural Task Force conducted a cultural competency presentation at the 2009 Mississippi Black Leadership Summit: "Expanding Our Ranks Unleashing Our Power". Members have attended workshops on Disparities Among
Native Americans, Resources for Spanish-speaking Communities National Networks of Libraries of Medicine, and Eliminating Mental Health Disparities: Challenges and Opportunities.

In FY 2009 and FY 2010, 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.

In FY 2011, NCBI trainings were conducted on October 14, 2010 at Alcorn State University, July 6, 2011 and July 7, 2011 at the Winston Choctaw Correctional Facility and July 8, 2011 at Region 1 Mental Health Center. The co-chair of the Multicultural Task Force (MCTF) conducted cultural competency training with law enforcement personnel in Lauderdale County, Singing River Services, Communicare, Life Help, and Holly Springs Junior High School.

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

Availability and Improvement of Psychosocial Rehabilitation Programs

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

Objective: To make available funding to support one drop-in center for adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Drop-in center

Indicator: Availability of funding through DMH to help support one drop-in center.

Measure: The number of individuals served by the drop-in center will be tracked

Comparison/Narrative: In FY 2010, the Drop-In Center in Gulfport, operated by the Mental Health Association of Mississippi served 62 adults (including homeless persons) with serious mental illness. Individuals served included 38 males and 24 females were served. Of this total, 29 were between the ages of 16-34; 6 were between ages 35-49; 10 were 50- 55 and 13 were in the 56-85 age range. The Resource Center in Corinth provided services to 30 adults with serious mental illness: 17 were females, 13 were males and 2 were under 41 years of age, while 28 were 41 to 60 years of age.

In FY 2011, the Drop-In Center in Gulfport, operated by the Mental Health Association of Mississippi served 110 adults (including homeless persons) with serious mental illness. Individuals served included 75 males and 35 females were served. Of this total, 26 were between the ages of 16-34; 33 were between ages 35-49; 27 were 50-55; and 24 were in the 56-85 age range.

Source(s) of Information: Documentation of grant award on file at DMH; monthly cash requests.

Special

Issue(s): None

Significance: The drop-in center, in addition to providing services to individuals with serious mental illness in the Gulf Coast area, will also provide technical assistance to programs with existing or new drop in centers.

Funding: Federal and state.

Was Objective Achieved? Yes

Availability and Improvement of Psychosocial Rehabilitation Programs

There are currently 65 clubhouse sites operational statewide. There are four ICCD certified clubhouses in Mississippi: Regions 5 (Greenville), Region 6 (Greenwood), Region 12 (Hattiesburg), and Region 9 (Jackson). Region 5 has been officially defined by ICCD as a Welcome Center. The ICCD Clubhouse in Greenville continues to provide a one week training program, which includes transitional employment to clubhouses in Mississippi. The DMH also continued to support Region 5 in maintaining a clubhouse thrift store in the community.

Training in the Clubhouse Model
In FY 2011, the Director of the ICCD-certified clubhouse in Greenville provided technical assistance about ICCD certification to 6 individuals. The Lexington Clubhouse in Region 6 (LifeHelp) is scheduled to have their first ICCD certification visit Dec. 5th-9th. The Greenwood Clubhouse in Region 6 has a recertification visit scheduled in April 2012. The Winona Clubhouse in Region 6 is currently conducting their self study as part of the certification process. The Indianola Clubhouse in Region 6 has a staff person and a clubhouse member scheduled to attend the Gateway House in Columbia, S.C. in October of 2011to receive training on the ICCD certification process.

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

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

Target: The Division of Community Services will increase efforts to explore existing relationships with the Department of Rehabilitation Services, Vocational Rehabilitation as related to better utilizing existing resources for individuals with mental illness

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Number of persons served by the public community mental health system who are employed.

Measure: Number of individuals employed (full- or part-time), including those in supported employment as a percentage of adults served by DMH certified and funded community mental health services.

Sources of Information: Aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 4: Profile of Adult Clients by Employment Status

Special Issues: Finding jobs is a challenge in many parts of the state, especially in the current economic environment. (The moving 12-month average unemployment rate for the state as of was 10.4%, compared to 7.7% at approximately the same time last year (March, 2009**)** and compared to the national average unemployment rate for April 2010 of 9.7%). DMH continued work in FY 2010 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 4. DMH plans to pursue collection of data in the Optional table 4A in FY 2011 to gain additional information on employment status for individuals with mental illness, as potentially associated with diagnosis.

Significance: The issue of employment, along with the issues of housing and transportation, are interrelated and must be addressed as necessary components of individuals' recovery, along with appropriate, evidence-based treatment, illness self-management and support, including support for families.

Action Plan: The DMH Division of Community Services will continue to make available technical assistance on the transitional employment component of the clubhouse programs described previously in the State Plan, since some TEPs have transitioned into permanent, competitive employment. The Division of Community Services will increase efforts to explore existing relationships with the Department of Rehabilitation Services, Vocational Rehabilitation as related to better utilizing existing resources for individuals with mental illness, such as job discovery, job development, preparedness and job coaching activities. Initiatives that provide support for employment, such as the Transportation Coalition activities and efforts to address the need for more housing options described in the State Plan, will also be continued.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**2011 Actual**
Performance					

Indicator					
Individuals employed as a percent of those served in the community	17.5	16.2%	15.1%	17.2%	15%
Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)	9541	9,437*	9158		9,898
Denominator: # of persons employed + unemployed + not in labor force (excludes "not available" status)	54,473	58,176*	60,690		65,834

Was objective achieved? Although the exact reasons are not readily apparent from the data, the number of employed people increased, and the number of both people unemployed and people not in the labor force increased. This is consistent with and may be reflective of overall general high unemployment rates.

Housing Options with DMH funding support	**Programs**	**Beds**	**Total Served as of mid-FY 2010**
Group Homes	26*	277*	277*
Halfway Houses	3	34	39
Supervised Housing	14	161	172

*****Does not include 48 group home beds operated by CMRC.

In an effort to consolidate and refine the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/IDD Services*, DMH examined standards for services provided to different populations that could be combined where they were addressed separately in the past; therefore, the standards for community living across target populations were examined and it is projected that draft revisions will address overlap in services standards and/or definitions across groups.

National Outcome Measure: 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 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and ongoing efforts to

improve data integrity might result in adjustments to baseline data.

Significance: Specialized outreach and coordination services are needed to identify and address the unique and often complex needs of individuals with mental illness who are homeless.

Action Plan: DMH will continue to provide funding and technical assistance to specialized programs providing outreach and coordination of services for individuals with mental illness who are homeless/potentially homeless, as described in detail under Criterion #4. The Division of Community Services will also continue to participate in interagency groups that address the needs of individuals who are homeless or potentially homeless described under Criterion #4. Activities to address the strategic planning specific to increasing housing options accessible to adults with serious mental illness and described in the State Plan will also continue.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% of adults reported homeless/in shelters	.8%	.8%	.79%	.8%	,76%
Numerator: # adults reported homeless/in shelters by DMH certified/funded providers	512	560	532		557
Denominator: # adults reported with living situations by DMH certified/funded providers, excluding persons with	63,410	59,625	67,431		73,124

living situation Not Available					

Was objective achieved? Yes

Model of the Case Management System

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

DMH currently has 143 case managers enrolled in the essential learning system for PCCMP (Provisionally Certified Case Management Professional) as of March, 2011. All of the enrolled participants are 100% compliant and in good standing, and five of the 143 participants are near completion of the total curriculum. Participants have two years to complete the certification process to be upgraded to full certification.

In FY 2011, Case Management Advisory Committee Educational/TA Topics were offered in the on-line training:
Resource Introduction /Overview: Mississippi Home Corporation's Home Saver's Program
Overview of the Council on Quality Leadership (CQL) Process for Determining and Strengthening Desired Outcome Measures for Individuals Served

Overview of the Recovery Person Centered Planning Model of Treatment
Overview of Division of Medicaid/HSM Review process and documentation requirements
Restructuring of Case Management Orientation and Case management Credentialing Procedures
Selection of the Essential Learning On-Line Training Service Curriculum for Case Management
Essential Learning: Live User Demonstration in Service for On- Line Case Management Training/Curriculum

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In FY 2010 and FY 2011, case management records continued to be reviewed for meeting the requirement to evaluate adults with serious mental illness who receive substantial public assistance for the need for case management services. As of mid-2011, 100% of the records reviewed reflected that this requirement had been met, that is, there were no citations issued regarding the requirement that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusals placed in writing.

Mental Health Transformation: Involving Consumers Fully in Orienting the Mental Health System Toward Recovery

Case Management Outreach

In FY 2011, 6000 brochures were distributed to case management providers throughout the state. The 15 community mental health centers, East Mississippi State Hospital, Mississippi State Hospital Community Services Divisions, private non profit agencies, and community events each received 300 brochures.

Technical Assistance to Case Managers
In FY 2011, three case management orientations were conducted. On October 14, 2010, 23 case managers were trained, February 18, 2011, 31 case managers were trained, and March 11, 2011, 24 case managers were trained.

Regional Acute Care/Crisis Stabilization System

In FY 2011, the transition of the six of the seven crisis stabilization units (operated by the state hospitals) to the community mental health centers began and was completed by the end of August 2010. The crisis stabilization unit (CSU) in Newton remained under the operation of Central MS Residential Center. However, all the CSU's began operating following the redesign blueprint at the Grenada CSU based on the DMH Operational Standards for crisis stabilization units (formally called intensive residential treatment programs) and acute partial hospitalization services. All CSU's now accept individuals on both an involuntary and voluntary basis. Additionally, the intensive residential treatment program in Gulfport, operated by Region 13 CMHC (Gulf Coast Mental Health Center) is now classified as a crisis stabilization unit. Therefore, MS now has eight CSU's certified for operation by the DMH. Additionally, the Division of Medicaid has proposed to include CSU services as a reimbursable service to be implemented during FY 2012.

Other Intensive Residential Treatment Programs

The intensive residential treatment program operated by Region 13 CMHC in Gulfport is now recognized as a CSU. The intensive residential treatment program operated by Region 6 CMHC was closed during FY 2010 since Region 6 now operates the CSU in Grenada and the intensive residential program was no longer needed. Additionally, the intensive residential treatment program operated by Region 15 in Vicksburg was closed during FY 2011 since the counties served by the program now fall within the Grenada CSU catchment area. The funding used for these two intensive residential treatment programs is now being used to support the development and sustainability of the programs of assertive community treatment; one based in Greenwood (Region 6) and one based in Vicksburg/Yazoo City (Region 15).

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

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

Assertive Community Treatment

In FY 2011, the PACT team in Greenwood (Region 6) became fully functional and began enrolling individuals into service. The Greenwood PACT team will also serve as a training site for any new PACT teams opened in MS. With the closure of the intensive residential treatment program in Vicksburg, Region 15 CMHC opted to use the funding provided by DMH for that program to open a PACT team to cover Vicksburg and Yazoo City (Warren and Yazoo counties.) The Region 15 PACT team hired staff and received training at the Region 6 PACT site. Individuals began to be enrolled into services by the Region 15 PACT team in the last months of FY 2011.

The 2011 DMH Strategic Plan indicates the development of additional PACT teams in MS as a priority. DMH will request additional funding from the State Legislature for the development of additional PACT teams during the 2012 Legislative session which falls in FY 2012. Additionally, the Division of Medicaid has proposed to include PACT services as a reimbursable service to be implemented during FY 2012.

Goal: Decrease utilization of state inpatient adult psychiatric services

Target: To reduce readmissions of adults to state inpatient psychiatric services by routinely providing community mental health centers with state hospital readmission data by county

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health services

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

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

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

Special Issues: DMH is continuing work on development of the data system to support collection of information for the core indicators on readmissions to state psychiatric inpatient facilities, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project. Data was reported through the Uniform Reporting System (URS) tables. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other national outcome measures. The current data system does not track individuals across

the community mental health and state hospital system; therefore, adults in those two systems, though there is some overlap, are likely to represent two different cohorts, that is, except for receiving a preadmission screening, not all adults served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Chancery Court system. DMH is continuing work to develop capacity to collect data from all funded/certified providers through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits and to have the capacity to track adults served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: As noted in the State Plan, CMHCs conduct pre-evaluation screening for civil commitment that is considered by courts in determining the need for further examination for and proceeding with civil commitment to the state psychiatric hospitals. Collaborative efforts to increase continuity of care across hospital and community services settings and increased focus on the provision of community-based services, including more timely access to crisis stabilization services are designed to prevent hospitalization and rehospitalization.

Action Plan: The Department of Mental Health will implement initiatives to provide community-based crisis stabilization services, to improve discharge planning and continuity of care for individuals transitioning from inpatient to community-based care, and to provide training on evidence-based, integrated treatment for persons with co-occurring disorders, which are described in the State Plan.

Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days and within 180 days: (URS Developmental Tables 20A and 20B)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2011**

	Actual	Actual	Actual	Target	Actual
Performance Indicator					
1. Decreased Rate of Civil Readmissions ~~at~~ to state hospitals within 30 days	3.5%	4.12%	4.1%	3.4%	3.2%
Numerator: Number of civil readmissions to any state hospital within 30 days	134	175	141		105
Denominator: Total number of civil discharges in the year	3845	4244	3479		3272
2. Decreased Rate of Civil Readmissions ~~at~~ to state hospitals within 180 days	17.3%	15.62	16.7	15.3%	15.19%
Numerator: Number of civil readmissions to any state hospital within 180 days	665	663	582		497
Denominator: Total number of civil discharges in the year	3845	4244	3479		3272

Was Objective Achieved? Yes

Goal: To reduce involvement of adults with serious mental illness in the criminal justice system.

Target: To continue to collaborate with CMHCs in providing training to law enforcement and to facilitate networking between the mental health system and law enforcement/justice systems to address jail diversion, law enforcement training, and linkage between community mental health services/jails/corrections.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Increase in the percentage of adults with serious mental illness served by the public

community mental health system reporting that they had been arrested in one year, but were not rearrested in the next year**.**

Measure: Percentage of adults with serious mental illness served by the public community mental health system who reported that they had been arrested in Year 1 (T1), but were not rearrested in Year 2 (T1)

Sources of Information: Uniform Reporting System (URS) data from Table 19A, which are based on results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH), and Division of Community Services grant reports.

Special Issues: In addition to the data being based on self-report, the low number of total responses to this survey item (105 in 2009) compared to the number of responses to other items on the survey should be considered in interpreting results of this measure. The low response rate to this survey item prior to 2009 may be due to survey instrument design (i.e., the addition of "branching" questions added to the end of the original *MHSIP Consumer Satisfaction* survey instrument to gather information on this NOM), which may be confusing to some respondents, as well as to some individuals' reluctance to respond to questions about their involvement in the justice system. Although increasing the survey sample size in 2009 increased the total number of responses, the number responding to this survey remains low in comparison to the total number of individuals responding to other survey items.

Significance: The Department of Mental Health will continue to explore other funding sources to support training of law enforcement personnel to develop appropriate responses to emergency situations involving individuals with mental illness, since law enforcement personnel may often be the first professional staff on the scene of an emergency and can be in a position to divert individuals to mental health services when needed and more appropriate. Increasing networking between the mental health system and law enforcement/justice systems will facilitate the development of more strategies to address issues related to criminal justice involvement, such as jail diversion, law enforcement training, and linkage between community mental health services/jails/corrections**.**

Action Plan: Because of budget restrictions, DMH will not continue funding support of law enforcement training provided by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers explore other avenues for training for law enforcement and other emergency services personnel and to explore additional opportunities to divert and/or decrease involvement of individuals with mental illness in the criminal justice system, such as described under Criterion 5.

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

Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
Performance Indicator					
% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	52%	69%	65%	68%	47%
Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	**13**	75	46		25
Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)	25	108	71		53

Was objective achieved? Yes

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 2010, the Co-Occurring Disorders Coordinating Committee met in September, 2010. The COD trainers updated the committee on the progress of the statewide training. As of September, 2010, 12 of the 15 community mental health center regions as well as MS State Hospital and South MS State Hospital had received training. An overview of the Co-Occurring Disorders Program was presented to the Planning Council on August 13, 2010. The number of regions trained to date and overview of the training curriculum were discussed.

In FY 2011, In FY, the Co-Occurring Disorders Coordinating Committee continued their efforts to advance to advance the knowledge and implementation of co-occurring best practices in the state. In an effort to save on travel costs, the committee corresponded via email and teleconference. As of September 2011, the initial co-occurring training plan had been completed. Recommendations have been make to include Co-Occurring Training Modules in the mandatory Essential Learning (E-Learning) Curriculum for DMH Certified/Licensed Mental Health Therapists, IDD Therapists, and A&D Therapists. The Co-Occurring Disorders Coordinating Committee, comprised of representatives from each region as well as DMH staff, has a meeting scheduled for November 22, 2011.

Source(s) of Information: Co-occurring Disorders Coordinating Committee minutes

Special Issues: None

Significance: The DMH allocates funds specifically for the provision of community-based services for individuals with co-occurring disorders. The committee continues to work on identifying and addressing services improvements.

Funding: Federal (CMHS) funds

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 2008 Projected	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Community Residential Dual Diagnosis Beds	12	12	12 beds; 23 individuals served	12	12 beds; 16 individuals served

Comparison/Narrative: In FY 2010, $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 23 individuals in FY 2010.

In FY 2011, $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 16 individuals in FY 2011.

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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Served–Dual Diagnosis	8598	9295	10,064	6500	10,812

Comparison/Narrative: In FY 2010, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 10,064 adults with co-occurring disorders of substance abuse and serious mental illness.

In FY 2011, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 10,812 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

Consumer Education/Support Programs

Goal: To provide family and consumer education and support

Target: To continue to maintain and support Consumer Education/Support programs.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of Consumer Education Program training.

Indicator: Information about the Mississippi Leadership Academy (MLA) will be made available to individuals with serious mental illness served through the public community mental health system.

Measure: The number of individuals who complete the Mississippi Leadership Academy (MLA)

Comparison/Narrative: In FY 2010, NAMI-MS provided 6 Family to Family classes in four (4) CMHC regions (Regions 2, 9, 13, and 15) in the state to a total of 76 family members. There were nine (9) Family to Family individuals trained as trainers in five (5) CMHC regions (Regions 2, 8, 9, 10, and 15) of the state. NAMI also offered its Peer to Peer education program; five classes were offered in Regions 6, 9, 10, and 14 serving a total of 52 individuals. Sixteen (16) individuals attended the two (2) classes of NAMI Basics: Parent Program in Regions 9 and 15. A total of 376 support group meetings were held in CMHC Regions 2, 4, 6, 9, 10, 12, 13, 14, and 15. There were 162 *In Our Own* Voice presentations made to 2224 attendees in CMHC Regions 2, 4, 5, 6, 8, 9, 10, 12, and 13. Additionally, 14 *In Our Own Voice* presenters were trained in 10 CMHC Regions (2, 3, 6, 8, 9, 10, 12, 13, 14, and 15). No Provider Education classes were taught during FY 2010.

In FY 2011, NAMI MS provided three Family to Family classes in regions nine and 15 to a total of 32 family members. There were 40 in Our Own Voice presentations with 834 attendees. No Peer-To-Peer Education trainings or Provider Education classes were taught. NAMI conducted 208 Connections/Consumer Support Group meetings to 1384 participants in regions 2, 9, 10, 13, and 14 and 90 Family Support Group meetings to 595 participants in regions 2,9,13,14, and 15. A Mississippi Leadership Academy (MLA) was conducted on Dec. 3-5, 2010. The 2010 academy had 18 graduates, bringing the total to 156. The MLA Board met three times in FY 2011. The goal of the MLA is to develop a board comprised of consumers to manage and conduct the 2012 academy. The MLA Board will convene in Feb. 2012 to begin the total transition to a consumer-led and taught academy.

Source(s) of Information: Consumer education program records; Grant program reports

Special Issues: The Consumer Education Programs provided or supported through the CMHC must be NAMI Peer to Peer, the Mississippi Leadership Academy or other program approved by the DMH. The targeted number of individuals to be served through the Illness Management programs (120) was not completely reached in FY 2008 (103 adults

received services). This reduced number was due to a change in administrative staff at NAMI-MS (which administers the Peer to Peer program) during that time period, and use of the organization's staff time to initiate the NAMI Connections support program during that year. The number of individuals targeted to participate in the Illness Management programs also reflects a decrease after FY 2008, including reductions in FY 2010 and FY 2011 because of reduced funding, as previously described.

Significance: The Mississippi Leadership Academy **is** made available to facilitate the development of consumer education and support groups throughout the state. Consumer education programs provide individuals with education about their illness, including coping skills, and facilitate individuals taking a more active role in their recovery. The programs also provide information about how to access and advocate for and about opportunities for the development of self-help groups.

Action Plan: The Mississippi Leadership Academy (MLA) will continue to be made available to individuals served by the 15 CMHCs, and the Division of Consumer and Family Affairs will facilitate the provision of written material for community mental health centers to provide to consumers and/or family members regarding recovery that will address the availability of NAMI Peer to Peer and consumer support programs, as well as the MLA.

National Outcome Measure: Programs for Illness Management and Recovery Skills (URS Developmental Table 17)

(1)	(2)	(3)	(3)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**2011 Actual**
Mental Health Transformation Performance Indicator					
Percentage of persons served who received illness management/recovery services*	.20	.14	.21**	.03	.03
Numerator: Number Receiving Illness Management/Recovery Services*	103*	73	120	15	17
Denominator: Number of persons with SMI served (community services)	52,312	53,910	57,186	49,000	60,717

**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).

Was Objective Achieved? Yes

Other Educational Opportunities

Objective: To make available, through local, state or national media, education/training opportunities and materials

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of consumer educational opportunities

Indicator: Continued availability of funding to support educational opportunities for consumers through local, state or national education/training opportunities.

Measure: DMH will continue to make available opportunities for consumers to participate in local, state, and/or national trainings and provide educational materials to on self empowerment, recovery, and/or illness management.

Comparison/Narrative: The annual Mental Health Consumer Conference was not held during FY 2010. The MS Mental Health Recovery Social Network website www.msrecoverynetwork.org was under development in FY 2010 by certified peer specialists, consumers and representatives of the DMH Division of Consumer and Family Affairs and the Office of Constituency Services. The primary purpose for the network is to connect individuals affected by mental illness to assist them in finding resources, educational opportunities and training, support groups on mental health issues, and to allow consumers to engage in discussion around recovery/resilience. The site is in the beta testing phase, and is projected to be available in FY 2011.

In FY 2011, the MS Mental Health Recovery Social Network website was upgraded to include information regarding Peer Specialists in Mississippi. The website will be "home" for individuals to learn and/or register for training events, complete the Certified Peer Support Specialist Exam, and learn about employment/volunteer opportunities to becoming a Certified Peer Support Specialist and/or Personal Outcome Measures Interviewer. The website will promote consumer information sharing and exchange through the use of forums and will feature a Creative Corner for individuals to post art, poetry, and links to other resources about mental health and recovery.

Special Issues: None

Significance: Continuing support of local, state and/or national education/training opportunities**.** Educational materials distributed will focus on recovery and empowerment, and will be

shared with consumers of mental health services, as well as family members, mental health professionals and other interested stakeholders.

Funding: CMHS block grant

Was Objective Achieved? Yes

Other Support Groups

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

Goal: To increase social supports/social connectedness of adults with serious mental illness (i.e., positive, supportive relationship with family, friends and community)

Target: To continue to support illness self-management and consumer support programs and other activities designed to facilitate individuals taking a more active role in their recovery.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Percentage of adults with serious mental illness served in the public community mental health system reporting positively regarding social connectedness**.**

Measure: Percentage of adults with serious mental illness who respond to the survey and who respond positively to items about social support/social connectedness on the MHSIP Satisfaction Survey

Sources of Information: Results of the MHSIP satisfaction survey from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH) and case management service plans (reviewed by DMH Division of Community Services staff).

Special Issues: DMH has worked with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* in FY 2006 - FY 2009 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

Significance: Improving the social support/connectedness of adults with serious mental illness receiving services is a key indicator in assessing outcomes of services and supports designed to support individuals in taking a more active role in their recovery. Case management facilitates linkage of services/resources for individuals with serious mental illness, ensuring that an adequate service plan is developed and implemented, reviewing progress, and coordinating services.

Action Plan: The Division of Community Services and the Division of Family and Consumer Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care, such as continued support of illness self-management programs (the Mississippi Leadership Academy), continued availability of training on person-centered planning, activities to develop peer specialist services and a statewide consumer coalition, and development of an education campaign that focuses on recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change. These initiatives support an individual identifying their strengths and taking a more active role in their recovery, as well as in providing opportunities to support other consumers in recovery. Case managers will also continue to provide linkage and referrals to community resources (such as illness self-management and support services).

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

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**2011 Actual**
Performance Indicator					
% age of Families of adult consumers reporting positively regarding social connectedness	71%	76%	75%	74%	85%
Numerator: Number of adult consumers reporting positively about social connectedness	**447**	1112	958		830
Denominator: Total number of adult consumer responses regarding social connectedness	629	1470	1,280		974

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.

Since FY 2007, DMH has continued to work with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 9 submission and are reflected in the performance indicator table. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

Significance: Improving the functioning of adults with serious mental illness receiving services (from their perspective) is a key indicator in assessing progress on other goals designed to improve the quality of services and support recovery-oriented systems change.

Action Plan: The Division of Community Services and the Division of Consumer and Family Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care that increases the active role individuals take in their recovery and dissemination of evidence-based practices, e.g., continued availability of training on person-centered planning,

development of an education campaign that focuses on recovery and identifying avenues at the state and local level for promoting recovery-oriented systems change, and the initiative to provide training on providing evidence-based, integrated treatment for persons with co-occurring disorders.

Improved Level of Functioning (URS Table 9)

Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
% age of Families of adult consumers reporting positively regarding functioning	72%	72%	67%	72%	74%
Numerator: Number of families of adult consumers reporting positively about functioning	**456**	1053	861		723
Denominator: Total number of adult consumer responses regarding functioning	629	1458	1,282		971

Was Objective Achieved? Yes

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

(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**2011 Actual**
Performance Indicator	29%	29%	29%	14%	43%
Numerator	2	2	2	1	3
Denominator	7	7	7	7	7

Goal: To promote use of evidence-based practices in the community mental health services system for adults.

Target: To continue activities to facilitate dissemination of evidence-based practices in Services for adults with serious mental illness

Population: Adults with serious mental illness

Criterion: Comprehensive Community-Based Mental Health Service System

Indicator: Information will be provided to maintain use of one evidence-based practice for adult services (illness self management) and to facilitate steps in dissemination of additional evidence-based practices (integrated treatment for individuals with co-occurring disorders of mental health and substance abuse and assertive community treatment (ACT)

Measure: The number of evidence-based practices for adults with serious mental illness implemented.

Comparison/Narrative: In FY 2010, data on two of seven evidence-based practices specified by SAMHSA as National Outcome Measures (NOMs) was reported (family psychoeducation and illness management and recovery). As described previously, the initiative to continue providing training on integrated treatment for co-occurring disorders of mental illness and substance abuse (through the Transformation Transfer Initiative) was implemented in FY 2010; however, reporting of data on the NOM for integrated treatment has not been included in this report, as fidelity in reporting has not yet been established. Also in FY 2010, a pilot program for ACT was initiated in one CMHC region (Region 6, LifeHelp, based in Greenwood); however, reporting of data on the NOM for ACT has not been include in this report since the program is in early stages of development.

In FY 2011, data on two of seven evidence-based practices specified by SAMHSA as National Outcome Measures (NOMs) was reported (family psychoeducation and illness management and recovery). The initiative to continue providing training on integrated treatment for co-occurring disorders of mental illness and substance abuse will be provided. However, reporting of data on the NOM for integrated treatment has not been included in this report, as fidelity in reporting has not yet been established. Also, in FY 2011, DMH continues to offer ACT in one CMHC region (Region 6, LifeHelp, based in Greenwood). DMH has started an additional ACT (Region 15, Warren-Yazoo, based in Vicksburg). Both programs are serving individuals and meeting reporting requirements to fidelity.

Sources of Information: Consumer education program (Mississippi Leadership Academy) records (grant program records)

Special Issues: As noted previously, the objective to provide family psychoeducation services through NAMI's Family to Family program was deleted for FY 2011 because of reductions in funding. The pace (and scope) of progress to facilitate dissemination of additional evidence-based practices (integrated treatment for individuals with co-occurring disorders and assertive community treatment) are likely to be impacted by the availability of funding resources.

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

Action Plan: Activities to maintain EBPs (family psychoeducation and illness self management) and to promote the dissemination of additional evidence-based practices (integrated treatment for co-occurring disorders and ACT) described in other sections in the State Plan were implemented. In FY 2011, data on three of seven evidence-based practices specified by SAMHSA as National Outcome Measures (NOMs) was reported (family psychoeducation, illness management and recovery, and ACT) as treatment for co-occurring disorders of mental illness and substance abuse (through reporting of data on the NOM for integrated treatment has not been included in this report, as fidelity in reporting has not yet been established. Also in FY 2011, programs for ACT were continued in two CMHC regions (Region 6, Lifehelp, based in Greenwood and Region 15, based in Vicksburg.)

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.)

Goal: To include in the State Plan a current estimate of the incidence and prevalence among adults with serious mental illness, in accordance with federal methodology.

Objective: To include in the State Plan an estimate of the prevalence of serious mental illness among adults in the state.

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Prevalence estimate methodology

Indicator: Utilization of revised estimated prevalence ranges of serious mental illness among adults in the FY 2011 State Plan (as described above), based on the final estimation methodology for adults with serious mental illness published in the June 24, 1999 Federal Register.

Measure: Inclusion of prevalence estimates derived using federal methodology in the FY **2011** Plan.

Comparison/Narrative: In FY 2009 and FY 2010**,** 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 2009 and FY 2010 State Plans were updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state 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 2,134,436 based on U.S. Census 2007 population estimates and was 2,155,638 based on U.S. Census 2008 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 115,260 in 2007 and 5.4% or 116,414 in 2008. 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.

In FY 2011, since current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating incidence and prevalence of serious mental illness among adults, in the FY 2011) State Plan,

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. Estimates in the FY 2011 State Plan were updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state, 2009, prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). As noted in the estimation methodology in the Federal Register, at this time, "...technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that in the future, "incidence and prevalence data will be collected."

The estimated number of adults in Mississippi, ages 18 years and above is 2,168,103 based on U.S. Census 2009 population estimates. According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 117,078 in 2009. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in 1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the "12-month prevalence is estimated nationally to be 5.4 percent..." As stated in the publication, these estimates are based on noninstitutionalized individuals living in the community. Also, as pointed out in the discussion of the federal estimation methodology, "only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time." The definition of serious mental illness among adults in Mississippi, described under this criterion, falls within the federal definition.

Source of Information: Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.

Special Issues: There are limitations to the interpretation of this prevalence estimate, explained above.

Significance: Estimates of prevalence are frequently requested and used as one benchmark of overall need and to evaluate the degree of availability and use of mental health services.

Funding: Federal and state funds

Was Objective Achieved? Yes

Quantitative Targets: Number of Individuals to be Served

Goal: To make available a statewide, comprehensive system of services and supports for adults with mental illness

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

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

Indicator: Total number of adults with mental illness served through the public community mental health system and the state psychiatric hospitals**.**

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

Special Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. Data was collected and reported through the Uniform Reporting System (URS) tables on persons served in the public mental health system age 18 and older by gender, race/ethnicity and includes data from the four state-operated inpatient psychiatric units for adults, as well as the DMH-funded community mental health service system. At this point, combined data (above) from the inpatient units and the community mental health programs may include duplicated counts. Also, two of the state-operated psychiatric hospitals provide only acute (short-term) psychiatric inpatient services; the other two hospitals provide both acute and continued (long-term) services. DMH has continued work on developing the capacity for collection of data for the National Outcome Measure on access to services, including addressing duplication of data across community and hospital systems and other issues, with support from the CMHS Data Infrastructure Grant (DIG). DMH has continued work in on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support

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

Significance: This objective provides an estimate of the service capacity of the public mental health system to provide services to adults with mental illness in FY 2011.

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**	**FY 2011 Actual**
Performance Indicator					
Total persons 18+ years served in public mental health system*	65,145	67,611	69,134	64,775	73,533

*****Includes adults with any mental illness (not just SMI) served in state inpatient units and public community mental health programs funded by DMH. Totals to date do not represent unduplicated counts across programs reporting; therefore, baseline data are projected as targets, as duplication in reporting is addressed in ongoing data infrastructure development activities; downward adjustments are anticipated.

Was Objective Achieved? Yes

Target or Priority Population to be Served Under the State Plan

Goal: To make available a community-based, statewide, comprehensive system of services and supports for adults with serious mental illness.

Objective: To provide community mental health services to adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Total number of adults with serious mental illness served

Indicator: The number of adults with serious mental illness who receive any community mental health services through the public system (15 CMHCs and Community Services Divisions of the state psychiatric hospitals.)

Measure: The number of adults with serious mental illness who receive services through the public community mental health system (minimum 49,000)

PI Data Table A2.1	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Adults with SMI Served	52,312	53,910	57,186	49,000	60,717

Comparison/Narrative: In FY 2010, a total of 57,186 adults with serious mental illness were served through the public community mental health system, which included 56,314 individuals served by the CMHCs and 872 adults served by the community services divisions of East MS State Hospital, Mississippi State Hospital and Central MS Residential Center.

In FY 2011, a total of 60,717 adults with serious mental illness were served through the public community mental health system, which included 60,143 individuals served by the CMHCs and 574 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) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

Significance: This objective provides an estimate of the service capacity of the public community mental health system to provide services to adults with serious mental illness in FY 2010**,** the priority population served by the DMH Division of Community Mental Health Services and the population eligible for services funded by the CMHS Block Grant.

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

Was objective achieved? Yes

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 – "Think Again"

Indicator: To reach 200,000 individuals during FY 2011

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

MH Transformation PI Data Table	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Individuals reached by Anti-stigma campaign	1.3 million reached	200,000	1.5 million	200,000	900,000

Comparison/Narrative: In FY 2010, in October 2009, DMH and the Mississippi Think Again Network launched the *Think Again* campaign, which is a statewide effort to help People change the way they think about mental health and shatter the silence around suicide. Mississippi's new anti-stigma campaign focuses on young adults. DMH developed three presentations for parents, students and teachers to coincide with the campaign. DMH also developed a campaign toolkit with press releases, talking

points, a letter to the editor template, public service announcements and other items. Since Oct. 1, 2009, a total of 104 *Think Again* and *Shatter the Silence* (anti-stigma/youth suicide prevention) presentations were conducted statewide, reaching more than 3,200 individuals. During a two-day period, nearly 300 students in the Meridian Public School District participated in the presentations. More than 800 youth who participated in the 4th Annual Mental Health Awareness Day in Newton received information about *Think Again*. Information was also presented to more than 350 youth at the Native American Youth Conference, the Hinds County School Counselors, Gulf Coast Counseling Association and others.

In FY 2010, DMH created an evaluation and developed a database to measure students' perceptions of mental illness prior to and after the anti-stigma presentations. A total of 1,979 evaluations were completed during FY 2010. According to the evaluations, prior to the presentation 48% of students reported a positive or very positive view of mental illness and persons with mental illness. After the presentation, 69.7% of students had a positive or very positive view of mental illness and persons with mental illness. The evaluation also revealed that the media and personal experiences influenced students' perceptions of mental health. A total of 81.3% of students reported that they could use information they learned during the presentation to help a friend in need.

In FY 2011, a total of 238 presentations were conducted reaching more than 27,746 students, teachers and parents. A total of 3,124 presentation evaluations were completed in FY11. Based on the evaluations, prior to the presentation 23.2% of students had a negative view of mental health. After the presentation, only 7.2% of students had a negative view. Prior to the presentation, only 44.7% of students had a 14 positive perception of individuals with mental illness. After the presentation, 76.5% of students had a positive perception. Based on the presentation, 83.8% of students believed they learned how to help a friend in need. Students reported that the media influenced their views/perceptions of mental illness the most.

Central Mississippi Residential Center hosted its annual Mental Health Awareness Days for students. A total of 11 schools and 1,800 students participated in the event. Presentations were also conducted for 2,000 students at Natchez High School.

In October 2010, packets were developed which contained a sample Think Again/Shatter the Silence card, a Talk About It card, and a letter offering presentations, suicide prevention posters and additional materials. Packets were sent to more than 1,000 6th – 12th grade school nurses and counselors. The mailing addresses and labels were provided by the Department of Education's Office of Healthy Schools. As a result of the mail out, DMH received requests for more than 13,000 cards and posters.

DMH received cost quotes for the mental health awareness/suicide prevention Web site targeting teenagers. In May, surveys were distributed to teenagers to determine what information they would like to see on the Web site. Based on the survey results, copy

for the Web site was completed in June. The goal is to have the Web site ready to launch in late August for the new school year. Information cards and posters promoting the Web site will be developed and provided to schools and colleges on the Gulf Coast and then to other areas of the state.

DMH met with the Mississippi National Guard in July and August 2010 to develop an awareness campaign for the military that would consist of several components including a resource guide for accessing services, a stress/mental health brochure, and suicide prevention posters to hang in restrooms at units statewide. The campaign will target stigma and increase awareness about mental health and suicide prevention. A draft resource guide, poster and brochure were approved by the Joint Behavioral Task Force. The National Guard was provided with 15,000 brochures, 1,500 posters, 500 resource guides in September to begin distributing at units statewide with a letter from the General promoting suicide prevention and mental health awareness. The National Guard distributed the information to 12,000 army and 2,500 air members. Information was included in DMH's newsletter and the National Guard's newsletter. The campaign was also launched at Weems Community Mental Health Center's Mind Matters event for military and family members in Meridian on September 23, 2010. A letter was sent by the DMH Executive Director on September 13, 2010, to all CMHCs encouraging them to participate in the campaign and contact their local National Guard units.

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 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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
Local Plans for Elderly Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

*Target modified due to Hurricane Katrina.

Comparative/Narrative: In FY 2010, all 15 CMHCs had submitted local plans for elderly services. The Elderly Task Force met in November of 2009 and July of 2010. In FY 2010, there were 87 elderly psychosocial programs, including 32 elderly psychosocial programs in CMHCs and 55 elderly psychosocial programs in nursing homes in Regions 1,3,4,5,6,7,8,9,10,11,12,14, and 15.

In FY 2011, all 15 CMHCs had submitted local plans for senior services. The Senior Task Force met in November of 2011 and July and 2011. In FY 2011, there were 96 Senior Psychosocial Programs, including 32 elderly psychosocial programs in CMHCs and 64 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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
Availability of training for staff in elderly psychosocial rehabilitation programs	Training provided for 33 staff from elderly psychosocial rehabilitation programs	Training provided for 20 staff from elderly psychosocial rehabilitation programs	Training for 24 staff from elderly psychosocial rehabilitation programs	Training provided for 10 staff from elderly psychosocial rehabilitation programs	Training provided for 24 staff from senior psychosocial rehabilitation programs

Comparison/Narrative: In FY 2010, the elderly psychosocial training site in Vicksburg, MS, provided training to six individuals; the elderly psychosocial program in Hattiesburg, MS, provided training to two individuals; and, the elderly psychosocial nursing home training site provided training to 16 individuals, for a total of 24 staff trained in FY 2010.

In FY 2011, the senior psychosocial training site in Vicksburg, MS, provided training to 16 individuals and the senior psychosocial program in Kosciusko provided training to 8 individuals, for a total of 24 staff trained in FY 2011.

Source(s) of Information: Division of Community Services monthly grant report forms

Special Issues: The number of staff targeted for training was reduced due to travel budget constraints**.**

Significance: Expansion of training in this area will address needs to enhance skills of community mental health services staff in providing services to elderly persons with serious mental illness

Funding: CMHS Block Grant, local funds

Was objective achieved? Yes

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 (833)

PI Data Table A4.1	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Served– Specialized Homeless	913	654	1150	833	1181

Comparison/Narrative: Comparison/Narrative:

In FY 2010, the five PATH-funded programs served 1150 individuals by program as follows: MSH Community Services – 212; EMSH Community Services – 40; Gulf Coast Women's Center – 140; Singing River Services – 400; Mental Health Association of Mississippi – 358.

In FY 2011, the five PATH-funded programs served 1150 individuals by program as follows: MSH Community Services – 212; EMSH Community Services – 40; Gulf Coast Women's Center – 140; Singing River Services – 400; Mental Health Association of Mississippi – 358.

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 2010, 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. A DMH staff member also attended the SSI/SSDI Outreach Access & Recovery (SOAR) Train-the-Trainer Program offered through SAMHSA. The SOAR program specifically targets easing the application process for SSI/SSDI and increasing the success rates of applications. This program will be extremely useful in helping homeless individuals with serious mental illness receive benefits more quickly, thereby facilitating access to stable housing.

In FY 2011, a DMH staff member served on the Project CONNECT committee, which is a coalition of community organizations from the Jackson-Metro area dedicated to serving persons experiencing homelessness. DMH staff members also attended Partners to End Homelessness committee meetings. Partners to End Homelessness is the Continuum of Care for the five-county central Mississippi region. A DMH staff member conducted a two day SOAR training seminar for the six county Mississippi Gulf Coast region, and two staff members became certified SOAR trainers for the state by attending the SOAR Train-The-Trainer program offered through SAMHSA. In addition, a DMH staff member attended the first annual national SOAR conference in Washington, D.C. The SOAR program specifically targets easing the application process for SSI/SSDI and increasing the success rates of applications. The program has been helpful in assisting homeless individuals with serious mental illness receive benefits more quickly, thereby facilitation access to stable housing.

Source(s) of Information: Minutes of workgroup meetings and/or Division Activity Reports

Special Issues: The DMH staff member who works with this committee and/or other appropriate DMH staff members will also participate in additional interagency workgroups addressing homelessness (such as the Partners to End Homelessness, the MS United to End Homelessness Coalition, and MISSIONLinks), as requested. The Division of Planning will collaborate with and integrate the activities of these workgroups, which has been ongoing, as needed into a broader strategic plan for housing for persons with mental illness.

Significance: By the DMH Division of Community Services or other appropriate DMH staff participating on various interagency workgroups concerned with the needs of homeless persons, including individuals with serious mental illness, opportunities for maximizing human and fiscal resources to address those needs in a coordinated manner are enhanced. DMH staff participation in groups concerned with the needs of all homeless individuals further ensures that any specialized needs or concerns of homeless persons who also have a serious mental illness are included in the work of those groups.

Funding: State, and federal funds

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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
Local Plans Addressing Transportation	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Comparative/Narrative: In FY 2010, all 15 CMHCs submitted community support plans, which were reviewed by the Division of Community Services. In FY 2010, 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, 13 CMHCs and the Community Services Divisions of MSH reported utilizing local public transportation

(buses, cabs, etc.) and Medicaid transportation.

In FY 2011, all 15 CMHCs submitted community support plans, which were reviewed by the Division of Community Services. In FY 2011, 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, 12 CMHCs and the Community Services Divisions of MSH 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

Criterion 5: Management Systems-

· **Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan.**

· **Provides for training of providers of emergency health services regarding mental health**

· **Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved 2011**

Goal: To increase funds available for community services for adults with serious mental illness.

Objective: The DMH will seek additional state funds for community mental health services for adults with serious mental illness.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Funding Increase Request

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

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

Comparison/Narrative: In FY 2010, DMH requested $30,400,000 for full funding of Medicaid Match for the CMHC program in its budget request for the fiscal year that began July 1, 2010; about 45% of these funds address children's services, the remainder addresses adult services. No additional funding was appropriated to DMH for the matching funds or any other purpose. CMHC match for FY 2011 will be paid one-half from DMH funds by using money from facility special fund cash balances; the other half will be contributed by the CMHCs.

In FY 2011, during the 2011 legislative session, for the fiscal year that began July 1, 2011, and ends June 30, 2012, DMH requested $1,803,000 general funds to replace the loss of an equal amount of federal funds under enhanced Federal share of Medicaid for residential programs operated by DMH facilities. DMH requested $20,000,000 for the state's one-half share of Medicaid match on payments received by the fifteen regional community mental health centers (with the CMHC's paying the other half). In addition, DMH requested $7,116,000 to restore funding to community based programs that were cut due to diverting funds to Medicaid match for a Home and Community Based Waiver Program for persons with IDD ($1,550,000), a loss of federal Social Services Block Grant funds ($3,366,000), and a loss of state source funds due to budgetary issues ($2,200,000). Approximately 50% ($3,558,000) of the amount requested to be restored is for community mental health programs with the remainder being for substance abuse services and services to persons with intellectual and developmental disabilities. DMH requested a total increase of $25,361,000 for mental health services.

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

Special Issues: Based on the most recent estimated use of funds of 55% for adult services of the total to be requested for adults' and children's community mental health services, this percentage is currently reflected in the projection for additional state matching funds for adult mental health services provided by CMHCs and funded through Medicaid (in preceding projected budget request).

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

Funding: State

Was objective achieved? Yes

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

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems
Brief Name: Number of DMH-certified/credentialed staff

Indicator: The number of individuals who hold a credential in the Mental Health Therapist program will be maintained by staff of the Division of Professional Licensure and Certification (PLACE); the number of Program Participants and those holding licensure in the Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.

Measure: The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees in the Licensed DMH Administrator program; the number of individuals who hold a credential in the Case Management Professional program. (Note: This measure includes individuals whose credentials have lapsed/expired.)

Comparison/Narrative: In FY 2010, a total of 158 Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional (CCMP-I) or Certified Case Management Professional-II (CCMP-II) credentials were awarded.

A total of 82 individuals currently hold the Licensed DMH Administrator credential, and a total of 14 individuals are currently Participants in the Licensed DMH Administrator credentialing program. In FY 2010, three individuals entered the Licensed DMH Administrator Program, and six Licensed DMH Administrator credentials were awarded. Each Participant continues to receive training in the area of administration through his/her participation in the Mississippi Certified Public Manager Program and his/her preparation for the required written examinations or his/her participation in DMH's leadership development program, Focus.

In FY 2011, a total of 774 individuals held a case management credential as a Provisionally Certified Case Management Professional (PCCMP) or Certified Case Management Professional (CCMP). A total of 100 individuals held the Licensed DMH Administrator credential or participated in the Licensed DMH Administrator Credentialing program. In FY 2011, a total of 1,211 individuals held a credential in the Mental Health Therapist Program.

Was objective achieved? Yes, however, the number of individuals holding a credential

in the Mental Health Therapist Program for FY 2011 is slightly lower than projected due to stagnant hiring patterns among our DMH certified programs in response to the struggling economy.

Source(s) of Information: DMH/PLACE database; PLACE staff

Special Issues: None

Significance: Existing certification/licensure programs implemented by the Department of Mental Health were authorized by the MS State Legislature and approved by the Governor in 1996 and 1997.

Funding: State funds

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

Credentialing Program	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target	FY 2011 Actual
Mental Health Therapists (all levels)	1,959	2,161	2,237		
Mental Health Administrators (all levels)	122	122/126	127		
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	_	-		_	
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	629/758	607	844		
Number of individuals who hold a credential in the Mental Health Therapist Program				1,275	1,211

Number of individuals how are Participants or who hold a credential in the Licensed DMH Administrator Program				97	100
Number of individuals who hold a credential in the Case Management Professional Program				100	774

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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual
# Pre-evaluation Screening Training Sessions	6	6; 95 trained	6	4	4; 87 trained

Comparison/Narrative: In FY 2010, there were six pre-evaluation screening training sessions in which 111 individuals were trained. Consumers and family members continued to share their perspectives of what was helpful and not helpful during their experience with the mental health system at the time of serious emotional difficulties. Two staff from Adams County Correctional Center attended to increase their knowledge of how to help their clientele.

In FY 2011, there were four pre-evaluation screening training sessions in which 87 individuals were trained. A consumer shared her perspective of helpful and not helpful experiences during periods of serious emotional difficulties. The curriculum was also

changed to include a segment of community services and potential alternatives to commitment**.**

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

Through planning aimed at improving community-based crisis and emergency services, the need for training of law enforcement was identified as a major need and included in the State Plan. Frequently, law enforcement officers may be among the first emergency personnel on the scene who interact with consumers and families in crisis, and they might also be involved in the civil commitment process. The DMH has an agreement with the MS Department of Public Safety to provide professional mental health staff from the CMHCs to provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. As a result, a curriculum was developed and implemented in 1997 for recruits being trained through the six state law enforcement academies. This curriculum was developed by the Law Enforcement Task Force, made up of family members, consumers, mental health providers and Department of Public Safety representatives. To also address the training needs of experienced law enforcement officers, the Law Enforcement Task Force developed a curriculum for in-service training, through which law enforcement officers currently in the field can receive continuing education credit, which was implemented in 1998. DMH certified trainers from throughout the state have continued to conduct either the recruit or in-service training. Additionally, in the Warden at the Harrison County jail made a video on the importance of communication between law enforcement and community mental health staff. The video's message urges law enforcement professionals to take advantage of law enforcement training provided by community mental health center staff.

In FY 2008 – FY 2010, DMH made funding available to 15 CMHCs to help support provision of law enforcement training. Thirteen of the fifteen CMHCs applied for and received funding. Funding amounts that were granted to CMHC's in FY2010 were continued in FY2011. Since the funding source changed from federal to state funds, this grant period was only nine months (October 2010– June 2011). During that time, there were 17 training sessions held with 446 personnel receiving the training.

In November 2010, DMH staff addressed the MS Chancery Clerks Association Conference, in December 2010, the Mississippi Sheriff's Association Conference, and in January 2011, the MS Association of Supervisors Conference. These presentations communicated DMH's desire to collaborate with law enforcement offices to provide education and support services for officers intervening with citizens experiencing mental illness crises. The presentations also communicated DMH's desire to help counties find alternatives to jails for holding people who have been committed and awaiting admission to a treatment facility.

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 MH DIG Quality Improvement project;
- Periodic review and Revision of the DMH Manual of Uniform Data Standards;
- Continued communication with and/or provision of technical support needed by DMH Central Office programmatic staff who are developing performance/outcome measures;

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

- Ongoing communication with service providers, including the common software users group

to assess technical assistance/training needs:

- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the MH DIG Quality Improvement project, if funded;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Measure: Progress on tasks specified in the Indicator.

Comparison/Narrative: In FY 2010, 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 needed 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. All fifteen regional community mental health centers and three out of four of the state psychiatric hospitals are presently submitting data that populates the database.

The 13 Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and MIS staff are embarking on work to enable the children's non-profit programs to 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; the task is projected to be 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 DMH continues work on the CDR.

DMH MIS has continued its approach 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 are 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 are also planned to facilitate communication among stakeholders.

In FY 2011, 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 needed 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. All fifteen regional community mental health centers and all of the state psychiatric hospitals are presently submitting data that populates the database.

The 13 Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and working with 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

Projected FY 2011 CMHS Block Grant Projected Expenditures by Type of Service for Adults with Serious Mental Illness

Service	**Projected Est. Expend.**
Individual Therapy	$353,761
Medication Evaluation/Monitoring	$79,523
Family Therapy	$3,804
Group Therapy	$26,283
Psychosocial Rehabilitation/Employment Enhancement	$616.799.48
Nursing Services	$43,340
IM/SC Administration of Psychotropic Medication	$1,558
Case Management /ICM	$ 741,829
Emergency	$34,264
Community Residential	$34,822
Consumer and Family Education/Support	$127,006
Peer Review/Technical Assistance	$32,376.52
Drop-in Center	$69,660
Adult Making A Plan (AMAP) Teams	$29,315
Transportation pilot program	$10,870
TOTAL	**$2,205,211**

Projected Allocation of FY 2011 CMHS Block Grant Funds for Adult Services by Region/Provider

Provider	Projected Allocation
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley Interim Executive Director	$99,167.14
Communicare 152 Highway 7 South Oxford, MS 38655 Sandy Rogers, Ph.D., Executive Director	$126,368.13
Region III Mental Health Center 2434 S. Eason Boulevard Tupelo, MS 38801 Robert J. Smith, Executive Director	$114,425.14
Timber Hills Mental Health Services P.O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Executive Director	$131,843.14*
Delta Community Mental Health Services P.O. Box 5365 Greenville, MS 38704-5365 Richard Duggin Executive Director	$121,818.00*
Life Help P.O. Box 1505 Greenwood, MS 38930 Madolyn Smith, Executive Director	2gfvvf32kmkqq1q15 $146,453.00*
Community Counseling Services P.O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director	$130,475.00*
Region 8 Mental Health Services P.O. Box 88	$134,349.00*

Brandon, MS 39043
Dave Van, Executive Director

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

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

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

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

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

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

Warren-Yazoo Mental Health Services $92,885.14
P.O. Box 820691
Vicksburg, MS 39182
Steve Roark, Executive Director

NAMI-MS $67,802.00
411 Briarwood Drive - Suite 401
Jackson, MS 39206
Tonya Tate, Executive Director

Mental Health Association of Mississippi $66,691.00
P.O. Box 7329

4803 Harrison Circle
Gulfport, MS 39507
Kay Denault, Executive Director

MS Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
Edwin C. LeGrand III, Executive Director

Funds to support consumer and family education/training opportunities at annual state conference, as well as other local, state or national education/training opportunities	$127,006.00
Funds to support enhancement of employment opportunities	Amt. included in awards for Region 5
Funds to support peer monitoring (Funds listed under DMH may be granted to local entities for implementation)	$32,376.52*
Funds to support pilot transportation project	**$10,870**
Total	**$2,205,211**

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

MISSISSIPPI STATE MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Larry Waller
Chairperson

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Phone: (662) 476-8035
email: dwaller@bellsouth.net

November 18, 2011

Edwin C. LeGrand III
Executive Director
Mississippi Department of Mental Health
239 North Lamar Street, Suite 1101
Jackson, MS 39201

Dear Mr. LeGrand:

On behalf of the Mississippi State Mental Health Planning and Advisory Council, I am writing to confirm that the Council received a draft copy of the *FY 2011 State Plan Implementation Report* for review before its submission to the Center for Mental Health Services (CMHS). The draft *Implementation Report*, including information that was being finalized, was included among agenda items at the November 18, 2011, meeting of the Council. The Council has been given the opportunity to submit questions and comments to staff at the Department of Mental Health concerning the draft *FY 2011 State Plan Implementation Report* before its submission to CMHS; contact information was provided to the Council members for submission of comments. The Council was informed that comments and corrections received after the deadline of November 25, 2011, will be communicated to the Council. Corrections or changes made in the continuing review of the report by staff at the Department of Mental Health between now and its submission will also be sent to Council members. Additionally, it is our understanding that the Council will have access to final *FY 2011 Uniform Data Tables* that are being submitted to CMHS, once final edits to the tables are made.

We appreciate the opportunity to review this report and are grateful to the service providers for providing the information needed by staff at the Department of Mental Health to fulfill requirements set forth by CMHS in compiling the *FY 2011 State Plan Implementation Report*. If I can provide you with more information about the Council's review of the report, please let me know.

Sincerely,

Larry Waller

Larry Waller
Chairperson