



**Mississippi  
Board of Mental Health  
and  
Mississippi  
Department of Mental Health**

**STRATEGIC PLAN  
FY 2012—2016**

**Focusing on the Future**

July 1, 2011

# Message from the Chair

The Strategic Planning Subcommittee of the Board of Mental Health continues its work to refine and focus the Strategic Plan. As we learn from our experiences each year, we are better able to focus the direction of the Strategic Plan and the Department of Mental Health's efforts. Our purpose has been to identify strategies and activities that will generate significant, measurable gains in transforming the services provided by DMH over the next five years.

This year's revision reflects the dedicated work of leaders from the Department's major service areas, Goal Leaders, and Goal Team members. They have been instrumental in helping narrow the Plan's focus while emphasizing priorities and developing observable performance indicators. This was accomplished in part by a reduction in the number of goals from nine to five. The Strategic Plan goals are now to:

*Maximize efficient and effective use of human, fiscal, and material resources*

*Continue transformation to a person-driven, community-based service system*

*Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers*

*Implement evidence-based or best practice models and service outcome measures*

*Utilize information/data management to enhance decision-making and service delivery*

The *Executive Summary* provides more details about these goals as well as recognizes those people who assisted with their development. I encourage you to review it.

As Chair, I want to thank all the Subcommittee members, Goal Leaders, Goal Team members and everyone who participated by responding to the committee's surveys and inquiries. It is only through the hard work and dedication of people from both public and private sectors that the vision of a community-based system of care will become a reality.

*Margaret Cassada, M.D., Chair*  
Board Strategic Planning Subcommittee

## STRATEGIC PLANNING SUBCOMMITTEE

Dr. Margaret Cassada, Board of Mental Health  
Mr. George Harrison, Board of Mental Health  
Mr. Johnny Perkins, Board of Mental Health  
Mrs. Rose Roberts, LCSW, Board of Mental Health  
Ms. Lisa Romine, Bureau of Interdisciplinary Programs  
Dr. Lydia Weisser, Mississippi State Hospital  
Ms. Lynda Stewart, Division of Children and Youth

# Foreword

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The Mississippi Department of Mental Health has accomplished many of its objectives set forth in the first two years of the Strategic Plan. It is because of the dedication and diligent work of our staff and partners that we have been able to achieve so much even during difficult budget times. However, now is not the time to stop. We must push forward with an emphasis on the people we serve and focus on more observable and measurable objectives.

The Strategic Plan is a living, breathing document that guides the future of the public mental health system. The purpose of the Strategic Plan is to re-evaluate the nature and manner of services/supports delivered by DMH, reinforce those that work, and make changes or create new services/supports where needs are not being met.

Along with a well-crafted plan, we believe partnerships are key to the success of the public mental health system. Partnerships with consumers, family members, advocates, community mental health centers, providers, professional associations, individual communities, DMH staff, and other state agencies are vital to the future.

Over the last few years, we have faced many obstacles due to budget cuts. The economic climate has changed since the first Strategic Plan was crafted. It is a difficult task to transform the public mental health system to more community-based and recovery-driven during one of the most serious budget crisis Mississippi has ever experienced.

By working together, I believe we can accomplish great things for the Mississippians we serve. As Henry Ford said, “Coming together is a beginning. Keeping together is progress. Working together is success.” My hope is that you will continue to work with us in supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual or developmental disabilities one person at a time.

Edwin C. LeGrand III

# Table of Contents

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Executive Summary	Page 1
Mission, Vision, and Values	Page 3
Philosophy	Page 4
Core Competencies	Page 5
Organizational Overview	Page 6
Services and Supports Overview	Page 8
Goals and Objectives	Page 12
Future Goals	Page 30
Implementation	Page 32
Acknowledgements	Page 33
Acronyms	Page 34

# Executive Summary

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The purpose of the Strategic Plan is to drive the transformation of the system into one that is outcome and community-based. With two years of strategic planning achieved, the Board of Mental Health began its annual review of the Strategic Plan in November 2010. The Board's 2011 Strategic Planning Subcommittee consisted of Board members Dr. Margaret Cassada, Mr. George Harrison, Mr. Johnny Perkins, and Ms. Rose Roberts; Central Office staff liaison, Ms. Lisa Romine; Clinical Services Director, Dr. Lydia Weisser, MSH; and Ms. Lynda Stewart, DMH Division of Children and Youth.

The Strategic Planning Subcommittee's charge was to review and revise as necessary the Strategic Plan, which serves as a map for guiding the continuing transformation of the DMH service system. The Board of Mental Health intends for the Strategic Plan to be a flexible, living document that has the ability to meet the needs of the people we support and face the challenges of an ever-changing environment. The Strategic Plan is an essential tool for system transformation.

With implementation of the FY 2011 Strategic Plan underway, the Strategic Plan Subcommittee met on November 18, 2010, to begin discussions on the revisions for FY 2012, taking into account current activities and the changing environment. The subcommittee began their efforts by agreeing that the stated vision, mission and values would remain. The next activity consisted of evaluating the existing goals. It was determined that further revisions were needed to narrow the Plan's focus and emphasize priorities and observable accomplishments. Thus, examining how to reduce the number of goals yet maintain the integrity of the plan began.

Prior to the next subcommittee meeting, the members reviewed the goals and made their recommendations. At the meeting on January 20, 2011, the Subcommittee decided to reduce the number of goals from nine to five so that more focus could be concentrated on activities producing observable outcomes.

Work then began on the review and revision of the goals' objectives and action plans. The nine Goal Leaders were asked to solicit the help of their Goal Team members and to make recommendations on which objectives/action plans to include keeping in mind the need to show observable and measurable outcomes.

During the review of each goal, objectives/action plans were removed from the Plan if they had been completed, duplicated in another goal, or now part of ongoing DMH activities. Objectives from goals that would no longer be a part of the Strategic Plan were also considered for inclusion along with new areas of focus. The Goal Leaders were: Kelly Breland and Dr. Suzanne Jourdan, Goal 1; Aurora Baugh, Goal 2; Thaddeus Williams, Goal 3; Debbie Ferguson, Goal 4; Dr. Mardi Allen, Goal 5; Wendy Bailey, Goal 6; Kris Jones, Goal 7; Michael Jordan, Goal 8; and Sabrina Young, Goal 9.

After this preliminary goal work, the Goal Leaders for FY 2012 began their review of the newly established five goals. These Goal Leaders were: Kelly Breland and Trisha Hinson, Goal 1; Jake Hutchins and Sandra Parks, Goal 2; Ashley Lacoste and Thaddeus Williams, Goal 3; Dr. Mardi Allen, Goal 4; and James Dunaway, Goal 5. DMH Bureau Directors: Lisa Romine, Kris Jones, Matt Armstrong, Diana Mikula, and Herb Loving, also provided input into the revision. A summary of the finalized goals follows.

*Goal 1* calls for DMH to continue to execute cost reduction measures and enhance its accountability and management practices to ensure the most efficient use of its resources. The goal also emphasizes the need to maximize funding through grants and available Medicaid waiver programs and services. Transforming to a community-based system will necessitate an increase in community capacity and require funding – both new funds and the reallocation of existing funds.

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

*Goal 3* addresses the methods by which DMH intends to increase individuals' access to care and services statewide. Goal 3 seeks to promote shared responsibility among communities, state and local governments, and service providers to build and strengthen the community-based system of care for individuals served by DMH. DMH recognizes that formal partnerships with traditional and nontraditional partners are critical to the overall success of the system of care.

*Goal 4* establishes the use of evidence-based or best practice (EBP) models and service outcomes. DMH embraces the importance of identifying and implementing EBPs within the system of care. By incorporating state-of-the-art research, clinical and administrative practices will consistently produce specific, intended results and meet scientific and stakeholder criteria for effectiveness.

*Goal 5* focuses on using data and available technology in decision-making. DMH will enhance its ability to communicate effectively and share data and information across the agency. DMH will fully implement and utilize its Central Data Repository project and continue activities to establish Electronic Health Records and a Health Information Exchange. With better data and analysis, decision-making will be enhanced.

Ongoing changes in the environment in which the mental health system operates continues to offer challenges. Obtaining our vision of a community based service system keeps DMH's dedicated staff and engaged stakeholders focusing on the future.

# Mission, Vision, and Core Values

## DMH Mission

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities, one person at a time.

## Vision

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

*A better tomorrow exists when...*

- All Mississippians have equal access to quality mental health care, services and supports in their communities.
- People actively participate in designing services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse and dementia has disappeared.
- Research, outcomes measures, and technology are routinely utilized to enhance prevention, care, services, and supports.

## Core Values & Guiding Principles

**People** We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice and provision of services to meet their unique needs.

**Community** We believe that community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

**Commitment** We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

**Excellence** We believe services and supports must be provided in an ethical manner, meet established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

**Accountability** We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

**Collaboration** We believe that services and supports are the shared responsibility of state and local governments, communities, family members, and service providers. Through open communication, we continuously build relationships and partnerships with the people and families we serve, communities, governmental/nongovernmental entities and other service providers to meet the needs of people and their families.

**Integrity** We believe the public mental health system should act in an ethical, trustworthy, and transparent manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

**Awareness** We believe awareness, education, and other prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

**Innovation** We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

**Respect** We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the public mental health system.

# Philosophy

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The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service, and support options for adults and children with mental illness or emotional disturbance, alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

# Core Competencies

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The Department of Mental Health established Core Competencies to serve as indicators of success in realizing its mission and vision. The core competencies are:

Allocating resources based on established priorities and agency vision

Demonstrating a strong commitment to excellence in services/supports delivery to promote positive outcomes for people

Practicing good stewardship with all resources

Exhibiting commitment to continual evaluation and a shift in focus to a community-based service system

Involving individuals, families, and self advocates in service planning, design, and delivery

Valuing and supporting the workforce by providing opportunities for continued education, training, and advancement

Possessing the cultural competencies necessary to work effectively with diverse people, families, communities, and workforces

Embodying an organizational culture of innovation, creativity, resourcefulness, self-evaluation, and continuous quality improvement

Collecting, interpreting, and applying information from a variety of sources when making decisions, preparing budget requests, and planning for and designing mental health policies, services, and supports

Establishing partnerships with others to achieve common goals and outcomes

Communicating effectively to promote awareness and prevention as well as to dispel the stigma of mental illness, intellectual/developmental disabilities, substance abuse, and dementia

# Organizational Overview

The Mississippi Department of Mental Health's organizational structure consists of three separate but interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-Operated Facilities and Community Services Programs.

## Board of Mental Health

The Board of Mental Health, the Department's governing body, is comprised of nine members appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the nine-member board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' terms are staggered to ensure continuity of quality care and professional oversight of services.

As specified in MISS CODE ANN Section 41-4-7 (1972), the Board of Mental Health is statutorily responsible for such primary duties as:

- Appointing an agency director,
- Establishing rules and regulations to carry out the agency's duties,
- Setting up state plans for major service areas,
- Certifying, coordinating and establishing minimum standards for programs and providers,
- Establishing minimum standards for operation of facilities,
- Assisting community programs through grants,
- Serving as the single state agency in receiving and administering funds for service, delivery, training, research and education,
- Certifying/licensing mental health professionals,
- Establishing and maintaining a toll-free grievance system,
- Establishing a peer review/quality assurance evaluation system, and other statutorily-prescribed duties.

## DMH Central Office

As specified in MISS CODE ANN Section 41-4-1 (1972), the purpose of the Department of Mental Health is:

to coordinate, develop, improve, plan for, and provide all services for persons of this state with mental illness, emotional disturbance, alcoholism, drug dependence, and an intellectual disability; to promote, safeguard and protect human dignity, social well-being and general welfare of these persons under the cohesive control of one (1) coordinating and responsible agency so that mental health and intellectual disability services and facilities may be uniformly provided more efficiently and economically to any resident of the state of Mississippi; and further to seek means for the prevention of these disabilities.

Furthermore, MISS CODE ANN Section 41-4-5 (1972) provides for the establishment of divisions within the Department of Mental Health.

The overall statewide administrative functions are the responsibility of the DMH Central Office. The Central Office is headed by an Executive Director and consists of seven bureaus and the executive division:

**Bureau of Administration**

**Bureau of Community Services**

**Bureau of Mental Health**

**Bureau of Interdisciplinary Programs**

**Bureau of Alcohol and Drug Abuse**

**Bureau of Workforce Development and Training**

**Bureau of Intellectual and Developmental  
Disabilities**

**Executive Division**

*The DMH Central Office also has a Legal Division and a Clinical Services Liaison*

## **DMH-Operated Facilities and Community Services Programs**

The DMH directly operates five psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual and developmental disabilities, and one specialized facility that serves adolescents with intellectual and developmental disabilities. The facilities serve designated counties or service areas and offer residential and/or community services for people with mental illness, substance abuse issues, intellectual and developmental disabilities, Alzheimer's disease and other dementia.

# Services/Supports Overview

The Mississippi Department of Mental Health (DMH) provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance abuse problems, and Alzheimer's disease and/or other dementia. It is our goal to improve the lives of Mississippians by supporting a better tomorrow...today.

The success of the current service delivery system is due to the strong, sustained advocacy of the Governor, State Legislature, Board of Mental Health, the Department's employees, consumers and their family members, and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

## Service Delivery System

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

***State-operated facilities.*** The DMH administers and operates five state psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual/developmental disabilities, and one facility that serves adolescents with intellectual and developmental disabilities. These facilities serve specified populations in designated counties/service areas of the state.

The psychiatric facilities provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance abuse. These facilities include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. Nursing facility services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, the psychiatric hospitals also provide transitional, community-based care. The Specialized Treatment Facility is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment. Central Mississippi Residential Center is a residential center for persons with mental illness.

The facilities for persons with intellectual/developmental disabilities provide residential services. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center. The facilities are also a primary vehicle for delivering community services throughout Mississippi. Mississippi Adolescent Center is a specialized facility for adolescents with intellectual/developmental disabilities.

***Regional community mental health centers (CMHCs):*** The CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 15 CMHCs make available a range of community-based mental health, substance abuse, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. DMH is responsible for certifying, monitoring, and assisting the CMHCs. The CMHCs are the primary service providers with whom DMH contracts to provide community-based mental health and substance abuse services.

***Other Nonprofit/Profit Service Agencies/Organizations:*** These agencies and organizations make up a smaller part of the service system. They are certified by the DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol/drug abuse services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

## Available Services and Supports

Both facility and community-based services and supports are available through the DMH. The type of services provided depends on the location and provider.

### ***Facility Services***

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

Acute Psychiatric Care  
Intermediate Psychiatric Care  
Continued Treatment Services  
Adolescent Services

Nursing Home Services  
Medical/Surgical Hospital Services  
Forensic Services  
Alcohol and Drug Services

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

ICF/MR Residential Services  
Psychological Services  
Social Services  
Medical/Nursing Services  
Diagnostic and Evaluation Services  
Community Services Programs

Special Education  
Recreation  
Speech/Occupational/Physical Therapies  
Vocational Training  
Employment Services

### ***Community Services***

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

## Services for Adults with Mental Illness

Crisis Stabilization Programs  
Psychosocial Rehabilitation  
Consultation and Education Services  
Emergency Services  
Pre-Evaluation Screening/Civil Commitment Exams  
Outpatient Therapy  
Case Management Services  
Halfway House Services  
Group Home Services  
Acute Partial Hospitalization

Elderly Psychosocial Rehabilitation  
Intensive Residential Treatment  
Supervised Housing  
Physician/Psychiatric Services  
SMI Homeless Services  
Drop-In Centers  
Day Support  
Mental Illness Management Services  
Individual and Family Education and Support

## Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Home  
Therapeutic Foster Care  
Prevention/Early Intervention  
Emergency Services  
Mobile Crisis Response Services  
Intensive Crisis Intervention Services  
Case Management Services

Day Treatment  
Outpatient Therapy  
Physician/Psychiatric Services  
MAP (Making A Plan) Teams  
School-Based Services  
Family Education and Support

## Services for People with Alzheimer's Disease and Other Dementia

Adult Day Centers  
Caregiver Training

## Services for People with Intellectual/Developmental Disabilities

Early Intervention  
Community Living Programs  
Work Activity Services  
Supported Employment Services  
Day Support  
Diagnostic and Evaluation Services  
ID/DD Waiver Attendant Care  
ID/DD Waiver Community Respite  
ID/DD Waiver In-Home Companion Respite

ID/DD Waiver Behavioral Support/Intervention  
Day Treatment  
ID/DD Waiver In-Home Nursing Respite  
ID/DD Waiver ICF/MR Respite  
ID/DD Waiver Day Habilitation  
ID/DD Waiver Prevocational Services  
ID/DD Waiver Support Coordination  
ID/DD Waiver Occupational, Physical, and  
Speech/Language Therapies

## Alcohol and Drug Abuse Services

Detoxification Services  
Primary Residential Services  
Transitional Residential  
Outreach/Aftercare

Prevention Services  
Chemical Dependency Units  
Outpatient Services  
DUI Diagnostic Assessment Services

## Additional Information

Additional information concerning the location of the facilities, services, and supports and descriptions of the specific services can be found on the DMH website: [www.dmh.ms.gov](http://www.dmh.ms.gov) or through DMH's Toll-Free Help Line Number: 1-877-210-8513.

# Goals and Objectives

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Using the mission, vision, and values, the Board of Mental Health developed five year goals to address the transformation of the DMH service system. These goals address the key issues of accountability/efficiency, a person-centered and driven system, access, community services, outcomes, partnerships, and information management.

The goals and objectives will guide DMH's actions in moving toward a community-based service system. Each goal's objectives include action plans, performance measures, timelines, and responsible parties. Furthermore, unless specified, these goals and objectives for change are inclusive of the populations DMH is charged to serve, and services developed and/or provided will take into account the cultural and linguistic needs of these diverse populations.

The system-wide goals are as follows:

- GOAL 1**     *Maximize efficient and effective use of human, fiscal, and material resources*
  
- GOAL 2**     *Continue transformation to a person-driven, community-based service system*
  
- GOAL 3**     *Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers*
  
- GOAL 4**     *Implement evidence-based or best practice models and service outcome measures*
  
- GOAL 5**     *Utilize information/data management to enhance decision-making and service delivery*

# Goal 1 Maximize efficient and effective use of human, fiscal, and material resources

## Objective 1.1 Increase efficiency within DMH

Action Plan	Performance Indicator	Target Year					Responsibility
		2011	2012	2013	2014	2015	
a) Continue to implement proven cost reduction measures across DMH programs/services	Amounts and relative percentages realized from expenditure reductions projects	2011	2012	2013	2014	2015	Bureau of Administration, assigned DMH staff
b) Implement at least one new Expenditure Reduction Project each year	By 2016, five projects developed and implemented with projected cost reductions reported	2011	2012	2013	2014	2015	Bureau of Administration, assigned DMH staff
c) Determine personnel needed to transform the service system	Increase in types and numbers of community-based support staff	2011	2012	2013	2014	2015	BCS, BIDD, BADA, BWDT
d) Increase efficient use of human resources by developing innovative cost-reduction measures concerning personnel (i.e. job sharing, flex scheduling of staff, etc)	Consolidated report with expenditure reductions and/or efficiencies in human resources	2011	2012	2013	2014	2015	BCS, BIDD, BADA, BWDT

## Objective 1.2 Maximize funding opportunities

Action Plan	Performance Indicator	Target Year					Responsibility
		2011	2012	2013	2014	2015	
a) Request and assist the Division of Medicaid with submission of at least one new community based waiver option based on established priorities	Waiver request submission	2011	2012	2013	2014	2015	BCS, BIDD, BADA
b) Apply for at least two new grants or additional funding in targeted areas: infrastructure and capacity building	Number of grants applied for and increase in the amount of grant dollars obtained	2011	2012	2013	2014	2015	Assigned DMH Staff
c) Collaborate with Division of Medicaid to amend the Medicaid State Plan to provide an array of person centered services (crisis intervention, peer/caregiver support, respite services, Wraparound facilitation, MAP teams)	Medicaid State Plan amendments submitted	2011	2012	2013	2014	2015	BCS, BIDD, BADA

Action Plan	Performance Indicator	Target Year					Responsibility
d) Maximize use of Elderly Disabled Waiver to provide services/programs for individuals with Alzheimer's Disease	Statewide availability of Alzheimer's day programs	2012	2013	2014	2015	2016	BCS
e) Initiate at least one blended funding option	Service/program targeted with plan of funding by interested parties	2012	2013	2014	2015	2016	BCS, BIDD, BADA

**Objective 1.3 Revise system-wide management and oversight practices to improve accountability and performance**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Maximize stakeholder input by streamlining the number of required task forces and steering committees	One representative committee for stakeholder input that meets requirements of applicable statutes or policies	2012	2013	2014	2015	2016	BCS, BIDD, BADA
b) Implement resource allocation strategy to support EB/BPs and service outcome models	Funding amounts (dollars) reallocated, itemized by service, and number and type of EBPs in use	2012	2013	2014	2015	2016	BCS, BIDD, BADA
c) Increase percentage of funding allocation to priority services (crisis services, housing, supported employment, case management, and early intervention/prevention)	Funding amounts (dollars) allocated to top three priorities	2012	2013	2014	2015	2016	BCS, BIDD, BADA
d) Increase effectiveness of coordination of MAP teams	State Level Coordinator hired for C&Y and Adult MAP Teams	2012	2013	2014	2015	2016	BCS
e) Publish an annual report that benchmarks like programs with established performance indicators/outcomes/national core indicators	Core indicator data base completed and benchmarking begun	2012	2013	2014	2015	2016	BCS, BIDD, BADA

## Goal 2 Strengthen commitment to a person-driven, community-based system of care

### Objective 2.1 Expand meaningful interaction of self advocates and families in designing and planning at the system level

Action Plan	Performance Indicator	Target Year					Responsibility
a) Provide opportunities for individuals and family members to participate in program development, service planning and recovery training	Active participation of peers and family members on Advisory Councils	2012	2013	2014	2015	2016	DCFA and all DMH
b) In collaboration with Division of Medicaid, develop an array of reimbursable peer and caregiver support services	Increased person-centered service options	2012	2013	2014	2015	2016	Executive Director, BCS, BIDD, BADA
c) Provide statewide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values	Increased knowledge of staff and increase in positive responses to the Council on Quality and Leadership's (CQL) 21 Personal Outcome Measures ©	2012	2013	2014	2015	2016	DCFA
d) Determine system's responsiveness to individual needs and desired outcomes	100% of certified programs evaluated according to the CQL's 21 Personal Outcome Measures ©	2012	2013	2014	2015	2016	DCFA and CQL Review Team
e) Incorporate Peer Recovery Supports Services into core services in DMH Operational Standards	Peer Recovery Specialist employed by DMH certified providers	2012	2013	2014	2015	2016	Executive Director, BCS, BIDD, BADA
f) Incorporate Family/Caregiver Supports Services into core services in DMH Operational Standards	Family/Caregiver Specialist employed by DMH certified providers	2012	2013	2014	2015	2016	Executive Director, BCS, BIDD, BADA
g) Expand representation in the Division of Consumer and Family Affairs to include at least one peer specialist or parent advocate for each population served by DMH	Representative for IDD included	2012	2013	2014	2015	2016	DCFA , BIDD, BADA

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
h) Evaluate effect of implementation of CQL's 21 Personal Outcome Measures © on the system's transformation to a recovery and resiliency model	Programs that were evaluated and trained met or exceeded national norms	2012	2013	2014	2015	2016	DCFA , CQL Review Team, BCS, BIDD, BADA
i) Identify barriers and make recommendations of the state's implementation of CQL's 21 Personal Outcome Measures ©	CQL's 21 Personal Outcome Measures © re-evaluated to determine if the state met the threshold and need to add or delete Personal Outcome Measures	2012	2013	2014	2015	2016	DCFA , CQL Review Team, BCS, BIDD, BADA

**Objective 2.2 Develop a comprehensive crisis response system**

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
a) Provide Crisis Stabilization Unit (CSU) services through each CMHC region	By end of FY 2016, a CSU in each CMHC region	2012	2013	2014	2015	2016	BCS
b) Evaluate CMHC-operated crisis stabilization units based on defined performance indicators for diversion, length of stay, and recidivism	Report of increase in diversion rate and reduction in length of stay and recidivism rate	2012	2013	2014	2015	2016	BCS
c) Provide readily available community crisis services	24/7 Mobile Crisis Teams services available for every county	2012	2013	2014	2015	2016	BCS, BIDD, BADA
d) Develop crisis support plans for individuals as a standard component of care and mitigation strategy	Crisis Support Plan developed for each person at risk of crisis, frequent user of inpatient services, or transitioning from inpatient/more restrictive placement or environment	2012	2013	2014	2015	2016	BCS, BIDD, BADA
e) Develop transition/step-down residential options for people leaving crisis stabilization units	Designation of at least two crisis apartment beds per CSU to assist individuals in transition back into the community	2012	2013	2014	2015	2016	BCS

Action Plan	Performance Indicator	Target Year					Responsibility
		2021	2022	2023	2024	2025	
f) Provide crisis and emergency respite services to people with intellectual/developmental disabilities	Pilot ed one ICF/MR group home or cottage on campus to be used solely for crisis respite services	2021	2022	2023	2024	2025	BIDD
g) Partner with CSUs operated by CMHCs to furnish crisis-oriented, specialized behavioral services on an as-needed basis for people with dual diagnosis of SMI/IDD	Crisis services provided at CSUs for persons with dual diagnosis	2021	2022	2023	2024	2025	BCS,BIDD
h) Provide crisis detoxification services	Crisis detoxification provided at CSUs	2021	2022	2023	2024	2025	BADA

**Objective 2.3 Increase statewide availability of safe, affordable and flexible housing options and other community supports for individuals**

Action Plan	Performance Indicator	Target Year					Responsibility
		2021	2022	2023	2024	2025	
a) Acquire sufficient staff time, training and resources to continue the development of service linkages with multiple housing partners at the state and regional levels	State Housing Coordinator hired or staff assigned	2021	2022	2023	2024	2025	BCS, BIDD, BADA
b) Identify support services and funding to sustain individuals living in permanent housing	Funds secured or allocated for needed supports	2021	2022	2023	2024	2025	BCS, BIDD, BADA
c) Provide an array of supported housing services	At least 500 persons received supported housing services/ supports across the state	2021	2022	2023	2024	2025	BCS, BIDD, BADA
d) Provide bridge funding for supported housing	At least 20 individuals received bridge funding to secure supported housing each year	2021	2022	2023	2024	2025	BCS, BIDD, BADA

**Objective 2.4 Provide community supports for persons transitioning to the community through participation in Money Follows the Person project**

Action Plan	Performance Indicator	Target Year					Responsibility
		2011	2012	2013	2014	2015	
a) Expand funded Waiver Services to enable individuals with IDD residing in DMH facilities to transition into the community	Increased number served by a minimum of 20 persons per year	2011	2012	2013	2014	2015	BIDD
b) Use ID/DD Waiver Services Reserve Capacity slots and Money Follows the Person services to transfer people from ICF/MRs to the community	By 2016, 138 people transitioned from ICF/MRs to community	2011	2012	2013	2014	2015	BIDD
c) Increase number served in ID/DD Waiver each year from those on the waiting list	ID/DD Waiver enrollment increased by 5% each year	2011	2012	2013	2014	2015	BIDD
d) Transfer people from nursing homes to community using Money Follows the Person services	By 2016, 240 people transitioned from nursing facilities to community	2011	2012	2013	2014	2015	BMH, BCS, BIDD
e) Establish interagency, multidisciplinary transition teams at the state ICF/MRs to assist individuals in making a seamless transition to community based services	5 Transition Teams	2011	2012	2013	2014	2015	BIDD

**Objective 2.5 Provide long-term community supports**

Action Plan	Performance Indicator	Target Year					Responsibility
		2011	2012	2013	2014	2015	
a) Expand Intensive Case Management services to enhance the diversion of persons in crisis away from inpatient treatment until less intensive services are needed	15 Intensive Case Management Teams across the state	2011	2012	2013	2014	2015	BCS
b) Expand PACT teams to support the integration and inclusion of persons needing long term psychiatric care	Funded 5 additional PACT teams across the state	2011	2012	2013	2014	2015	BCS

Action Plan	Performance Indicator	Target Year	Responsibility
c) Provide Community Support Teams to promote and support the independent living of individuals served	Funded and developed 15 Community Support Teams across the state	2021 2022 2023 2024 2025 2026	BCS

**Objective 2.6 Provide supported employment services**

Action Plan	Performance Indicator	Target Year	Responsibility
a) Increase number of individuals assisted with employment	At least 500 individuals with SMI/SED/A&D/IDD obtained jobs	2021 2022 2023 2024 2025 2026	BCS, BIDD, BADA
b) Assist in the reentry of individuals with mental illness back in the workplace	Employment Specialist employed by DMH certified providers	2021 2022 2023 2024 2025 2026	BCS, BIDD, BADA
c) Increase supported employment for individuals with IDD and decrease reliance on Work Activity Services	Number of people transitioned to supported employment from Work Activity	2021 2022 2023 2024 2025 2026	BIDD

**Objective 2.7 Expand specialized services**

Action Plan	Performance Indicator	Target Year	Responsibility
a) Increase and improve integrated treatment service options for co-occurring disorders in adults with SMI and children/youth with SED (SMI/A&D, SED/A&D, SMI/IDD, SED/IDD)	Number of co-occurring integrated treatment sites increased	2021 2022 2023 2024 2025 2026	BCS, BIDD, BADA

Action Plan	Performance Indicator	Target Year					Responsibility
b) Provide additional services/programs to serve transition-aged youth and young adults with SED	Two additional MTOP sites	2012	2013	2014	2015	2016	BCS
c) Expand early intervention services for children 0-5 to mitigate/remediate developmental disabilities including SED	Plan developed to expand early intervention programs for children ages 0-5 years of age in every CMHC region	2012	2013	2014	2015	2016	BCS, BIDD
d) Increase availability of in-home respite for caregivers of individuals with Alzheimer's, SED, SMI, and IDD	Number of additional respite providers	2012	2013	2014	2015	2016	BCS, BIDD

## Goal 3 Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers

### Objective 3.1 Establish equitable and timely access to services statewide

Action Plan	Performance Indicator	Target Year					Responsibility
a) Design integrated planning lists procedures to better identify types and locations of needed services/supports in order to increase options for home and community-based service provision	Integrated planning lists for BIDD and BMH	2012	2013	2014	2015	2016	BIDD, BMH
b) Develop strategies to address barriers to timely access	Strategies developed to reduce average length of wait times in community service programs	2012	2013	2014	2015	2016	BCS, BIDD, BADA, BMH,
c) Increase access to mental health care/services through expanded use of telemedicine	Increased number of providers in mental health system utilizing telemedicine/telehealth	2012	2013	2014	2015	2016	BCS
d) Develop a searchable database on DMH's Web site for the public to locate available services in their community	Database developed and available on DMH website	2012	2013	2014	2015	2016	IS, OCS, Public Information Director

### Objective 3.2 Expand and increase effectiveness of interagency and multidisciplinary approaches to service delivery

Action Plan	Performance Indicator	Target Year					Responsibility
a) Increase participation of the MS Band of Choctaws Indians in assessment, planning, and service delivery process	Appointments made to state level advisory councils	2012	2013	2014	2015	2016	Executive Director, BCS, BIDD, BADA

Action Plan	Performance Indicator	Target Year					Responsibility
		2020	2021	2022	2023	2024	
b) Increase partnership activities between local entities and community providers such as hospitals, holding facilities, CSUs and CMHCs to establish triage, treatment, and diversion plans	MOUs and documentation of outreach and action accomplished through mutual efforts	2020	2021	2022	2023	2024	BCS, BIDD, BADA, BMH
c) Collaborate with the Veterans Administration (VA) to increase the provision of A&D services to veterans within the local community	Contracting of 2 or more regional CMHCs and free standing programs with the VA for bed space for veterans in the community	2020	2021	2022	2023	2024	BCS
d) Expand MAP teams for children and youth with SED and IDD	MAP Teams available in all 82 counties	2020	2021	2022	2023	2024	BCS, BMH
e) Increase the utilization and practice of Wraparound for children and youth with SED and/or IDD	Wraparound model utilized by each certified CMHC for those children/youth and their families deemed necessary	2020	2021	2022	2023	2024	BIDD
f) Expand adult MAP teams	Adult MAP Teams available in 15 counties	2020	2021	2022	2023	2024	BADA, BCS
g) Facilitate work with state and local partnerships to increase jail diversion programs	Increased number of jail diversion programs, mental health courts, holding facilities and CIT programs	2020	2021	2022	2023	2024	BCS
h) Continue participation with the Mississippi Transportation Initiative	Increased availability of transportation	2020	2021	2022	2023	2024	BCS, BIDD

Action Plan	Performance Indicator	Target Year					Responsibility
		2021	2022	2023	2024	2025	
i) Adapt Operation Resiliency with the Veterans Administration care centers	Joint campaign to provide awareness and information on local behavioral health services	2021	2022	2023	2024	2025	BCS, BIDD, BADA, DMH facilities
j) Develop strategies to facilitate integration of mental illness, IDD, and addiction services with primary health care	Plan developed to increase use of integrated services	2021	2022	2023	2024	2025	BCS, BIDD, BADA
k) Continue development of multi-agency comprehensive approach for substance abuse prevention among adolescents	Develop joint efforts with community partners	2021	2022	2023	2024	2025	BCS, BIDD, BADA
l) Develop collaboration between faith-based organizations and mental health system to enhance access to services	Pilot a faith-based Emotional Fitness Center between a local faith-based organization and a mental health provider	2021	2022	2023	2024	2025	BCS, BADA

## Goal 4 Implement use of evidence-based or best practice models and service outcome measures

**Objective 4.1 Implement EB/BP models in priority service areas as a community norm/standard to support positive outcomes for individuals**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Select EB/BP where identified models are available that meet state specific criteria for each of the required core services and DMH identified priority services including crisis services, supported employment, and person-Centered planning	Specific treatment models selected for required services	2012	2013	2014	2015	2016	Committee of Stakeholders including DMH and Certified Programs, BCS, BIDD, BADA, individuals receiving services, family members, Clinical Services/ Best Practices Liaison
b) Develop timelines for implementation of the selected models endorsed by DMH for core services and DMH priority services	Implementation plan	2012	2013	2014	2015	2016	Representatives from DMH and Certified Programs, BCS, BIDD, BADA, Clinical Services/Best Practices Liaison
c) Pilot EB/BP models throughout the state	By end of FY13 and thereafter, DMH certified programs will have piloted at least one model for more than 6 months from the state endorsed EB/BP list	2012	2013	2014	2015	2016	DMH and Certified Programs, BCS, BIDD, BADA, Clinical Services/Best Practices Liaison
d) Increase the frequency of workforce development opportunities offered to providers (by DMH) focused on EBP/BP models	At least 5% increase in EB/BP training opportunities each year and demonstrated increase in knowledge of participants	2012	2013	2014	2015	2016	BWDT, BCS, BIDD, BADA, Clinical Services/Best Practices Liaison

**Objective 4.2 Develop service outcomes in service areas as a community norm/standard of care to support positive outcomes for individuals**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Provide opportunities for consultation, training and review of emerging or promising models found to be effective	“Innovations in Practice” published at least twice yearly highlighting effective treatment models promoting training opportunities on emerging or promising models	2012	2013	2014	2015	2016	BWDT, BCS, BIDD, BADA, Clinical Services/Best Practices Liaison
b) Require current references that substantiate the efficacy and effectiveness of service model utilized for required service areas where no specific EB/BP models are available	Review the utilization of current research and literature in the applicable service area	2012	2013	2014	2015	2016	BCS, BIDD, BADA, Clinical Services/Best Practices Liaison

**Objective 4.3 Evaluate and monitor outcomes of treatment models**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Establish evaluation criteria for each of the core services and DMH priority services to address efficacy and effectiveness	By July 1, 2012, a set of criteria for each of the core services and DMH priority services will be implemented	2012	2013	2014	2015	2016	Representatives from DMH and Certified Programs, BCS, BIDD, BADA, BMH, Clinical Services/Best Practices Liaison, stakeholders from DMH facilities, certified programs and service recipients
b) Incorporate evaluation criteria into the program review process conducted by the DMH monitoring team	Monitors will include approved program evaluation in monitoring visits	2012	2013	2014	2015	2016	DMH monitoring team

# Goal 5 Utilize information/data management to enhance decision-making

## Objective 5.1 Maximize reporting potential of collected data

Action Plan	Performance Indicator	Target Year					Responsibility
		2011	2012	2013	2014	2015	
a) Refine/evaluate reports on client level data from CDR for appropriateness/clinical-programmatic	Reports reviewed for appropriateness	2011	2012	2013	2014	2015	Clinical/service staff IS Staff
b) Modify CDR to allow for capturing length of wait data	Include "waiting" as a service in order to track length of wait	2011	2012	2013	2014	2015	IS Staff
c) Disseminate monthly reports when/where necessary (admissions, discharges, recidivism)	Reports produced and disseminated	2011	2012	2013	2014	2015	IS Staff
d) Generate other reports needed based on data elements currently collected for client tracking	Reports produced and disseminated	2011	2012	2013	2014	2015	IS Staff
e) Expand reporting capabilities of the CDR by creating procedures for requesting one time reports	Availability of ad hoc reports	2011	2012	2013	2014	2015	IS Staff
f) Eliminate duplication in data collection and reporting (electronic and manual)	Streamlined data collection among bureaus and divisions	2011	2012	2013	2014	2015	IS Staff
g) Create applications for viewing and creating reports from website	Website reporting	2011	2012	2013	2014	2015	IS Staff

**Objective 5.2 Develop/expand an electronic collection and reporting system for new reports**

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
a) Determine what software/program will be used across all	Report summarizing recommendations	2012	2013	2014	2015	2016	DMH Representative
b) Determine what new reports are required (i.e., Annual Operational Plan, Certification Visit Reports, Provider Management System, Outcome, Managed Care, Disparity Data, etc.) and for whom (ie. Central office, C & Y Services, CMHCs, etc.)	Recommendation made on needed reports	2012	2013	2014	2015	2016	Executive Director, Bureau/Division Directors
c) Define data for required report	Data elements identified	2012	2013	2014	2015	2016	DMH Representative
d) Design standardized reports with timelines for implementation	Reports designed	2012	2013	2014	2015	2016	DMH Representative
e) Implement collection and reporting	Reports produced	2012	2013	2014	2015	2016	DMH Representative

**Objective 5.3 Establish an electronic exchange of health information between DMH facilities and programs, and MS Health Information Network (MSHIN)**

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
a) Determine DMH participation cost for MSHIN	Calculation of cost per facility to participate in MSHIN	2012	2013	2014	2015	2016	DMH Representative

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
b) Determine DMH facilities for joining MSHIN	As approved by DMH, number of facilities which join MSHIN	2012	2013	2014	2015	2016	DMH Representative
c) Report MSHIN Board actions quarterly	Information provided on how actions impact DMH	2012	2013	2014	2015	2016	DMH Representative
d) Determine communication pathway among HIE and EHR	Post evaluation, provided recommendation of pathways	2012	2013	2014	2015	2016	DMH Representative

**Objective 5.4 Establish electronic health record (EHR) systems at DMH facilities and programs (as mandated and approved by DMH)**

Action Plan	Performance Indicator	Target Year					Responsibility
		2012	2013	2014	2015	2016	
a) Provide education of federal and state policy on healthcare reform to DMH Electronic Health Record (EHR) committee members, facility directors and IT directors	Score on healthcare reform test	2012	2013	2014	2015	2016	Goal Objective Leader, DMH Electronic Health Record Committee
b) Evaluate usefulness and feasibility of Medicaid Electronic Health Record (MEHR) database	Report on associated costs, incentives, and penalties for non-compliance of use EHR	2012	2013	2014	2015	2016	Goal Objective Leader, DMH Electronic Health Record Committee
c) Develop strategy and priority for implementing EHR systems at DMH facilities and programs	Implementation activities and timeframe developed	2012	2013	2014	2015	2016	Goal Objective Leader, DMH Electronic Health Record Committee
d) Pursue adoption, implementation and upgrades (A/I/U) of EHR	100% implementation of EHR at qualifying programs	2012	2013	2014	2015	2016	Goal Objective Leader, DMH Electronic Health Record Committee

**Objective 5.5 Develop a Health Information Technology (HIT) strategy for DMH including policies, standards, and technical protocols while incorporating cost saving measures**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Perform Network Security Audit	100% participation and remediation of network security of DMH central office and facilities	2012	2013	2014	2015	2016	Goal Leader and Facility Director (or as designated)
b) Standardize IT Policies and disaster recovery Standard Operating Procedures (SOPs)	Review and standardization of 100% of IT policies and SOPs	2012	2013	2014	2015	2016	Goal Leader and Facility Director (or as designated)
c) Determine future technology needs	Standardization of technology use and dollars saved	2012	2013	2014	2015	2016	Goal Leader and Facility Director (or as designated)

# Future Goals

## Fiscal Year 2017 and Beyond...

The goals and objectives for Fiscal Years 2012-2016 are the foundation of the Department of Mental Health's Strategic Plan. However, long-range planning is an essential component of any strategic plan. This section includes generalized objectives for Fiscal Year 2017 and beyond. With the successful completion of short-term objectives, it is expected that these longer-range objectives will become more specific as the time to implement them moves closer.

### Goal 1 Maximize efficient and effective use of human, fiscal, and material resources

*Explore the use of fiscal intermediaries as a method of allowing individuals greater control over how and where they receive services*

*Increase tiered service options*

*Obtain new funding for emerging services*

*Increase flexibility in use of funds to support new and innovative services*

### Goal 2 Continue transformation to a person-driven community-based service system

*Include a self advocate on the Board of Mental Health*

*Develop certification for Transition/Community Resource Peer Specialist (Bridger)*

*Determine need for certification of peer specialist in other specialized areas such as Disaster Relief, Housing, Dual Diagnosis, Forensics, Crisis Intervention, Young Adult, and Family*

*Utilize Consumer Satisfaction Survey data as a resource in measuring a program's overall performance*

*Promote the inclusion of information about the importance of consumer and family involvement into curricula for areas of study such as social work, psychology, counseling, etc.*

*Create a seamless system of community care for individuals with mental health needs*

*Provide crisis services statewide for IDD and A&D*

*Assess the need for new and emerging services*

*Expand the growth of service capacity for existing home and community-based waivers and expand the populations served by the waiver programs*

### **Goal 3 Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers**

*Implement a “No Wrong Door” (single point of entry) approach to accessing information and referral services*

*Integrate mental health care/services with primary health care*

*Increase availability of services at partner locations*

*Implement a true system of care to wrap all services around individuals and their families*

*Increase collaboration and funding from local governments*

### **Goal 4 Implement evidence-based or best practice models and service outcome measures**

*Incorporate evidence-based or best practices in all services supported with funding from DMH*

*Establish a research and development center*

### **Goal 5 Utilize information/data management to enhance decision-making and service delivery**

*Increase scope of data analyses by employing a full-time Data Analyst*

*Develop electronic identification card system*

# Implementation

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With the Board of Mental Health's approval of the Strategic Plan, work will begin immediately on action plans for FY 2012. As in the two previous years, implementation of the Plan is based upon goals, objectives, action plans, and strategies. Each of the five goals consists of a leader and team members who work throughout the year to meet measurable and observable performance indicators.

While progress is ongoing, quarterly reports are developed and presented to the Board. Reports are also posted on DMH's Web site for the public to view. Quarterly reports provide a tracking mechanism to show progress and areas which need to be addressed.

Funding continues to be a roadblock to full implementation of a more community-based and recovery-focused system. Research, partnerships and creative thinking are necessary to overcoming this and other roadblocks. By working with partners statewide, we can reach our ultimate goal of supporting a better tomorrow for individuals who have mental illness, intellectual or developmental disabilities, substance abuse problems, and Alzheimer's disease and other dementia.

# Acknowledgements

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Listed below are individuals who contributed to specific sections of the revised Strategic Plan.

## *Goals, Objectives, and Action Plans*

Lisa Romine, Bureau of Interdisciplinary Programs  
Dr. Lydia Weisser, Department of Mental Health Medical Director  
Kelley Breland, Mississippi State Hospital  
Dr. Suzanne Jourdan, Mississippi State Hospital  
Trisha Hinson, Bureau of Community Services  
Aurora Baugh, Bureau of Community Services  
Veronica Vaughn, Bureau of Intellectual and Developmental Disabilities  
Ashley Lacoste, Bureau of Intellectual and Developmental Disabilities  
Thaddeus Williams, Bureau of Community Services  
Debbie Ferguson, Central Mississippi Residential Center  
Sandra Parks, Bureau of Community Services  
Jake Hutchins, Bureau of Community Services  
Dr. Mardi Allen, Clinical Services Liaison  
Wendy Bailey, Central Office  
Kris Jones, Bureau of Intellectual and Developmental Disabilities  
Kathy VanCleave, Bureau of Community Services  
Michael Jordan, Bureau of Workforce Development and Training  
Sabrina Young, South Mississippi State Hospital  
James Dunaway, Mississippi State Hospital  
Cyndi Nail, Mississippi State Hospital

## *Strategic Plan Document Preparation*

Lisa Romine, Bureau of Interdisciplinary Programs  
Wendy Bailey, Central Office  
Ashley Lacoste, Bureau of Intellectual and Developmental Disabilities  
Lynda Stewart, Bureau of Community Services

# Acronyms

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A& D	Alcohol and Drug
BADA	Bureau of Alcohol and Drug Abuse
BCS	Bureau of Community Services
BIDD	Bureau of Intellectual and Developmental Disabilities
BIP	Bureau of Interdisciplinary Programs
BMH	Bureau of Mental Health
Board	Board of Mental Health
BP	Best Practices
BWDT	Bureau of Workforce Development and Training
C & Y	Children and Youth
CDR	Central Data Repository
CIT	Crisis Intervention Training
CMHC	Community Mental Health Centers
CO	Central Office
CSU	Crisis Stabilization Unit
CQL	Council on Quality and Leadership
DCFA	Division of Consumer and Family Affairs
DMH	Department of Mental Health
EBP	Evidence-Based Practice
EHR	Electronic Health Records
HIE	Health Information Exchange
ICF/MR	Intermediate Care Facilities for the Mental Retarded
I/DD	Intellectual/Developmental Disabilities
IS	Information System
IT	Information Technology
ITS	Information Technology Service
LPC	Licensed Professional Counselor
MAP Teams	Making-a-Plan Teams
MSHIN	Mississippi Health Information Network
MOU	Memorandum of Understanding
MTOP	Mississippi Transitional Outreach Program
PACT	Program of Assertive Treatment
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOP	Standard Operating Procedures