

**MISSISSIPPI DEPARTMENT  
OF MENTAL HEALTH  
COMMUNITY MENTAL  
HEALTH SERVICES  
FY 2016 – 2017 STATE  
PLAN**



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# **SECTION I**

# **STATE INFORMATION**

**FACE SHEET COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

**I. State Agency to be the Grantee for the Block Grant**

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

**II. Contact Person for the Grantee of the Block Grant**

**First Name:** Diana  
**Last Name:** Mikula  
**Agency Name:** Mississippi Department of Mental Health  
**Mailing Address:** 239 North Lamar Street, 1101 Robert E. Lee Building  
**City:** Jackson  
**Zip Code:** 39201  
**Telephone:** 601-359-1288  
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**Email Address:** [diana.mikula@dmh.state.ms.us](mailto:diana.mikula@dmh.state.ms.us)

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

**From:** 7/1/2013  
**To:** 6/30/2014

**IV. Date Submitted**

**Submission Date:**  
**Revision Date:**

**V. Contact Person Responsible for Application Submission**

**First Name:** Jake  
**Last Name:** Hutchins  
**Telephone:** 601-359-1288  
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# Letter of Designation from Governor

# Letter for Submission of State Plan

# **Certifications and Assurances**

# **MISSISSIPPI DEPARTMENT OF MENTAL HEALTH** **MISSION STATEMENT**

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

# **MISSISSIPPI DEPARTMENT OF MENTAL HEALTH** **VISION STATEMENT**

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 use, and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

## **Philosophy of the Department of Mental Health**

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 DMH 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. The 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. The 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-centered, community-based, and outcomes and recovery-oriented.

## Core Values and Guiding Principles of the Department of Mental Health

**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 the 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, met 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, families, and service providers. Through open communication, we continuously build relationships.

**Integrity:** We believe the public mental health system should act in an ethical and trustworthy 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, 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 mental health system.

# **SECTION II**

# **PLANNING STEPS**

# Step 1: Assessment of the Strengths and Needs of the Service System

## Overview of the State Mental Health System

**The State Public Mental Health Service System** is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

**The Service Delivery System** is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**The Board of Mental Health** governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

**The Department of Mental Health Central Office** is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of bureaus.

**The Bureau of Administration** works in concert with all bureaus to administer and support development and administration of mental health services in the state.

**The Bureau of Community Mental Health Services** has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's disease/other dementia. The Bureau of Community Services provides a variety of services through the following divisions: Division of Children and Youth Services, Division of Alzheimer's Disease and Other Dementia, Division of State Planning and the Division of Adult Crisis Response.

**The Bureau of Alcohol and Drug Services** is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance use problems. The overall goal of the state's substance use service system is to provide a continuum of community-based, accessible services, including prevention, outpatient, detoxification, community-based primary and transitional residential treatment, inpatient and recovery support.

**The Bureau of Mental Health** is responsible for the planning, development, and supervision of an array of services for individuals served at the state's six state behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes. This public service delivery system is comprised of four psychiatric hospitals; Central

Mississippi Residential Center, a mental health community living program; and the Specialized Treatment Facility, a psychiatric residential treatment facility for adolescents with mental illness and a secondary need of substance use prevention/treatment.

**The Bureau of Intellectual and Developmental Disabilities** is responsible for planning, development, and supervision of an array of services for individuals in the state with intellectual and developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive IDD programs for individuals with intellectual and developmental disabilities, the Mississippi Adolescent Center, an adolescent rehabilitation center for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services.

**The Bureau of Quality Management, Operations and Standards** is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH standards, oversight of agency and provider emergency management/disaster response systems, management of the serious incident reporting system for DMH certified providers, operation of DMH's information and referral services, and oversight of constituency services.

**The Bureau of Outreach, Planning and Development** is responsible for the agency's strategic planning process, internal and external communications, public awareness campaigns, transformation to a Person-Centered and Recovery Oriented System of Care, special projects, workforce development, and professional licensure and certification

## **Functions of the Mississippi Department of Mental Health**

**State Level Administration of Community-Based Mental Health Services:** The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

**State Certification and Program Monitoring:** Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

**State Role in Funding Community-Based Services:** The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

**Services/Supports Overview:** The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use

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, the State Legislature, the 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: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**State-Operated Programs:** The DMH administers and operates four state behavioral health programs, one mental health community living program, a specialized behavioral health program for youth, five regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use. These programs include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. The Specialized Treatment Facility is a specialized behavioral health program for adolescents with mental illness and a secondary need of substance use prevention/treatment. Central Mississippi Residential Center is a community living program for persons with mental illness. The programs for persons with intellectual and developmental disabilities provide residential services. These programs include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center. The programs are also a primary vehicle for delivering community services throughout Mississippi. Mississippi Adolescent Center is a specialized program for adolescents with intellectual and 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 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs. CMHCs are the primary service providers with whom the DMH contracts to provide community-based mental health and substance use 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 and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

## **Administration of Community-Based Mental Health Services**

**State Level Administration of Community-Based Mental Health Services:** The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies. The DMH is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in, and/or facilitates numerous avenues for ongoing communication with consumers, family members, and services providers.

**State Mental Health Agency's Authority in Relation to Other State Agencies:** The DMH is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance use services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan. The role of State agencies in the delivery of behavioral health services is addressed in: Support of State Partners.

**MISSISSIPPI DEPARTMENT OF MENTAL HEALTH  
COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS**

<p>Region 1: Coahoma, Quitman, Tallahatchie, Tunica</p>	<p>Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267</p>
<p>Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha</p>	<p>Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521</p>
<p>Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union</p>	<p>LIFECORE Health Group Ricardo Fraga, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595</p>
<p>Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto</p>	<p>Timber Hills Mental Health Services Charlie D. Spearman, Sr., Executive Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883</p>
<p>Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower</p>	<p>Life Help Phaedre Cole, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211</p>
<p>Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston</p>	<p>Community Counseling Services Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347</p>
<p>Region 8: Copiah, Madison, Rankin, Simpson, Lincoln</p>	<p>Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)</p>
<p>Region 9: Hinds</p>	<p>Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director 3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400</p>

<p>Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith</p>	<p>Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821</p>
<p>Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson</p>	<p>Southwest MS Mental Health Complex Steve Ellis, Ph.D., Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173</p>
<p>Region 12: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne</p>	<p>Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641</p>
<p>Region 13: Hancock, Harrison, Pearl River, Stone</p>	<p>Gulf Coast Mental Health Center Jeffrey L. Bennett, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132</p>
<p>Region 14: George, Jackson</p>	<p>Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690</p>
<p>Region 15: Warren, Yazoo</p>	<p>Warren-Yazoo Mental Health Services Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031</p>

## **Strengths and Needs of the Service System**

### **Strengths: Children with Serious Emotional Disturbance (SED) and Their Families**

- The Mississippi Transitional Outreach Program (MTO), a Children's Mental Health Initiative targeting transitional youth age, 14–21 years, entered into the sixth and final year of implementation on October 1, 2014. Three local community mental health center regions are implementing the program which provides evidence-based practices, wraparound facilitation, and training for professionals and youth, and education and resources on independent living skills for youth enrolled. On July 1, 2013, the DMH received a four year grant to expand this program to two additional counties.
- The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances with complex needs that usually require the intervention of multiple state agencies. The DMH provides flexible funding to this state-level team and to local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Human Services (DHS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services, as well as adolescent offender programs across the state.
- The DMH and the Division of Children's Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training staff from other child and family support service agencies. Collaborative training initiatives include Wraparound Facilitation and System of Care by staff at the Innovations Institute at the University of Maryland; MAP team development and expansion; Youth Suicide Prevention; Cultural Diversity; Trauma-Informed Care; juvenile mental health issues; and cross-system improvement trends and best practices.
- Efforts have been initiated to provide training in evidence-based practices to clinicians in the CMHCs and other nonprofit programs to improve responses to youth and families in crisis, including those with a history of trauma. Through contractual services with nationally certified trainers, the DMH provides collaborative learning for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS).
- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. The DMH continues to fund ten CMHCs for the provision of mental health services in the local detention centers. Services include assessments, Community Support Services, SPARCS (group therapy), Cognitive Behavioral Therapy (CBT), Wraparound Facilitation, and medication monitoring.
- The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance

of youth with serious emotional or behavioral challenges.

- The DMH, in collaboration with the Division of Medicaid and the University of Southern Mississippi's School of Social Work, developed the Mississippi Wraparound Initiative.

### **Needs: Children with Serious Emotional Disturbance (SED) and Their Families**

- Decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers. Availability of additional workforce, particularly psychiatric/medical staff at the local community level, specializing in children's services, is an ongoing challenge in providing and improving services.
- Address children with co-occurring disorders of serious emotional disturbance (SED) and intellectual and developmental disabilities (IDD) in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross-system collaboration and education.
- Continue to work to improve the information management system is needed to increase the quality of existing data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.
- Continue to collaborate with the Division of Medicaid to further define and develop Intensive Outpatient Psychiatric Services and expand children's mental health provider's capacity to provide this intensive service.
- Continue the development of specialized curriculums for Certified Parent/Caregiver Support Specialists and Certified Youth/Young Adult Support Specialists.

### **Strengths: Services for Adults with Serious Mental Illness (SMI)**

- Implementation of the comprehensive service system for adults with serious mental illness reflects the DMH's long-term commitment to providing services, as well as supports, that are accessible on a statewide basis.
- The DMH has created the Division of Crisis Response to address the development of crisis response capabilities in the state. The Division of Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24-hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and de-escalation techniques.

- The DMH funds seven 16–bed CSUs and partially funds one 24–bed CSU throughout the state. The DMH also partially funds one 8–bed CSU for adolescents. All CSU takes voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.
- The DMH also operates two 50–bed acute psychiatric hospitals for adults. The acute care/crisis services are located in the north and in the south part of the state.
- The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. MCErTs assess adults and children with mental illness, substance use, and intellectual and developmental disabilities. MCErTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.
- The perspectives of families and individuals receiving services are important in planning, implementing, and evaluating the adult service system through involvement in numerous task forces, peer review process, provider education, and the person-directed planning process. The Bureau of Outreach, Planning and Development has implemented initiatives to provide more specific guidance regarding the purpose and structure of local advisory councils, has developed a draft of a manual to provide technical assistance to the local advisory councils, and plans to develop a strategy for dissemination of educational information to the local councils.
- The Bureau of Outreach, Planning and Development coordinates the Peer Support Specialist Program. This program is designed to promote the provision of quality Peer Support Services and to enhance employment opportunities for individuals with serious mental illness, substance use, and intellectual/developmental disabilities. Certified Peer Support Specialists are required by the DMH to be an integral component of PACT and MCErT.
- The Bureau of Outreach, Planning and Development oversees the Peer Review Process for the DMH using The Council on Quality Leadership’s Personal Outcome Measures © to assess the impact of services on the quality of life for the people receiving services. Individuals and family members are trained to conduct interviews to determine if outcomes are present for the individual and if the supports needed are present in order to achieve those outcomes. The Division of Recovery and Resiliency maintains the commitment to ensure individuals and family members have the skills and competencies needed for meaningful participation in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs.
- The Office of Consumer Support is responsible for maintaining a 24–hour, 7–days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide Prevention Lifeline. The Office of Consumer Support responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.
- The DMH contracted with the Technical Assistance Collaborative (TAC) to develop a statewide housing plan. The State has requested funding for this project through Mississippi

Home Corporation. The goal is to increase the number of safe, decent affordable housing options that include a range of choices for Mississippians.

- The DMH will address housing and support service needs of persons who are experiencing chronic homelessness who have a substance use or co-occurring use and mental health disorder through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).
- The DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. The sites are in Regions 2, 7, 10, and 12.
- Navigate is an evidence-based program designed to assist individuals who have experienced their first psychiatric episode. Navigate is used in conjunction with PACT services to identify and alleviate future episodes.
- Trainers in both the adult and youth versions of Mental Health First Aid have been certified by the DMH. Mental Health First Aid is public education program that helps the public identify, understand, and respond to signs of mental illness, substance use disorders and behavioral disorders. These trainers provide education to community leaders including: pastors, teachers, and civic groups, and families and friends who are interested in learning more about mental health issues.
- All DMH Behavioral Health Programs have implemented person-centered discharge practices which are in-line with the agency's transformation to a person-centered and recovery oriented system of care.
- The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.
- The Division of Alzheimer's Disease and Other Dementia provides awareness activities and educational training programs for family caregivers, direct care workers and other professional service providers, information and referral, adult day service programs, and annual education conferences. In addition, the Division works in collaboration with other state and nonprofit agencies on a variety of programs and projects such as development and implementation of the State Strategic Plan for Alzheimer's Disease, law enforcement training, adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services.
- The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets.

- The DMH has provided more than 25 Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members. ASIST is a 2–day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.
- Mississippi has eight Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto County), Region 6 (serves Leflore County), Region 9 (serves Hinds), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.
- The Specialized Planning Options to Transition (SPOT) Team is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.

### **Needs: Services for Adults with Serious Mental Illness (SMI)**

- For most people with a mental illness, employment is viewed as an essential part of their recovery. Most people with severe mental illness want to work as it is a typical role for adults in our society and employment is a cost-effective alternative to day treatment. Approximately 2 of every 3 people with mental illness are interested in competitive employment but less than 15% are employed due to lack of opportunities and supports.
- The DMH has chosen to develop and make available supported employment services based on the Dartmouth & Individual Placement and Supports Model (IPS). IPS supported employment helps people with severe mental illness work at regular competitive jobs of their choosing. Although variations of supported employment exist, IPS (Individual Placement and Support) refers to the evidence-based practice of supported employment.
- People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Approximately 40% of clients who obtain a job with help from IPS become steady workers and remain competitively employed a decade later.
- Continued work to increase access to and to expand safe and affordable community-based housing options and housing related supports statewide for persons with serious mental illness is needed to support recovery. Accomplishing this goal will involve focusing the system response on supporting individuals to choose among community-based options for a stable home, based on their individual needs and preferences, which is consistent with the best practice of Permanent Supportive Housing (PSH).
- The Division of Crisis Response is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public

Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. The DMH makes grants available to a CMHC region to provide training to law enforcement to facilitate the establishment of two Crisis Intervention Teams (CIT) in the state.

- Continued focus on improving transition of individuals from behavioral health centers back to their home communities is needed. The development of strategies to better target and expand intensive supports through a team approach is being addressed. The DMH will continue to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.
- Work to improve the quality of data contained in the information management system, as well as to expand data analysis, continues. The goal is to integrate new and existing data into a comprehensive quality improvement system.

### **Underserved Racial and Ethnic Minority and LGBT Populations**

The Mississippi Department of Mental Health addresses the needs of racial and ethnic minorities and LGBT populations in a variety of ways. The DMH staff has been trained as trainers in the California Brief Multicultural Competence Scale (CBMCS) Training Curriculum. The CBCMS Training is intensive, didactic, and interactive as well as a widely regarded training curriculum that provides tools for working with diverse populations. DMH also received technical assistance regarding cultural and linguistic competence from The Department of Child & Family Studies (CPS) at the University of South Carolina. In addition, the Department of Mental Health collaborated with System of Care communities to create a Behavioral Health Disparities Impact Statement. This statement describes a plan of how grantees will use data to monitor disparities and implement strategies to improve access, service use, and outcomes among the disparate population.

To address LGBT populations, the Department of Mental Health funded a LGBTQ Youth Resource Guide developed by Rise Above for Youth, a local LGBTQ Youth Advocacy and Training Agency. This Guide is available in print and on DMH's website. DMH also partners with the Mississippi Safe Schools Coalition which provides Safe Zone training to communities across the state including current System of Care grantee sites. Safe Zones provide LGBTQ youth with an environment that is supportive, understanding, and trustworthy. Staff are trained and prepared to provide youth in need with help, advice, or simply, someone to listen. The Mississippi Department of Mental Health sponsors an Annual Statewide Trauma Conference which had approximately 600 individuals attend from various disciplines serving individuals affected by trauma and mental health issues. In September of 2015, a new component was added to the conference to specifically inform and train law enforcement officers across our state. Breakout sessions on LGBTQ are infused in the conference to include trauma implications of LGBT and best practices.

### **American Indians**

The Mississippi Department of Mental Health and the Mississippi Band of Choctaws collaborate to promote mental health awareness and education. Staff from the Mississippi Band of

Choctaws Behavioral Health Services participate and assist in planning the Annual Statewide Trauma Conference sponsored by DMH. Additionally, a staff member from the Mississippi Band of Choctaws Behavioral Health Services participates on the DMH Multicultural Task Force. The mission of this task force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. In turn, staff from DMH participates and assist in planning the Annual Youth Conference sponsored by Choctaw Behavioral Health Services. Choctaw Behavioral Health Services also participated in a train the trainer workshop on the California Brief Multicultural Competence Scale (CBMCS), which as previously stated, is a training curriculum that provides tools for working with diverse populations. The local governance council with a System of Care community also includes a representative from the Mississippi Band of Choctaws Behavioral Health Services. An individual interested in or in need of mental health services can find contact information for the Mississippi Band of Choctaws Behavioral Health Services on the current Mississippi Department of Mental Health Website.

### **Persons with Disabilities**

Children and youth with disabilities, such as hearing and/or visual impairments, are served initially by local MAP (Making a Plan) Teams. If local resources are unavailable, the child or youth is referred to the State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, and includes representatives from the Department of Mental Health; the Department of Human Services; the Division of Medicaid; the Attorney General's Office; the Department of Health; the Department of Education, the Department of Rehabilitation Services and Families As Allies for Children's Mental Health. The team meets once a month and on an as-needed or emergency basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need specialized or support services. Representatives from the Mississippi School for the Deaf and Blind participate as needed on the team and work in collaboration with staff from the Division of Children and Youth Services to develop appropriate plans to meet the needs of children and youth in our state with hearing and visual challenges.

### **Military Men and Women**

While our military and its members are strong, there are times when they too struggle with stress, anxiety, depression and even thoughts of suicide. Sometimes military men and women feel embarrassed or ashamed to seek help and others may not know what help is available. Members of the military make a promise to protect our country. Mississippians are now making a promise to support them when they are on and off the field of battle.

The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families. The campaign, Operation Resiliency, reaches National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. Stress can be a part

of everyday life for many people. However, members of the military can face a constant and severe stress that many civilians may never know. It can lead to depression, anxiety, relationship problems, aggression, thoughts of suicide, financial problems, accidents, alcohol and drug use, domestic violence and hopelessness. It is important for members of the military to understand when to seek help.

## **Criterion 1: Comprehensive Community-Based Mental Health Systems**

### **Adults**

An adult with SMI refers to persons ages 18 and older; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person’s role or functioning in family, school, employment, relationships, or community activities.

### **Crisis Response**

The DMH has created the Division of Crisis Response to address the development of crisis response capabilities in the state. The Division of Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24-hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and de-escalation techniques.

### **Crisis Stabilization Units**

The DMH funds seven 16-bed CSUs and partially funds one 24-bed CSU throughout the state. The DMH also partially funds one 8-bed CSU for adolescents. All CSU takes voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

### **Housing**

The DMH has contracted with the Technical Assistance Collaborative (TAC) to develop a statewide housing plan. The goal is to increase the number of safe, decent affordable housing options that include a range of choices for Mississippians. The DMH will address housing and support service needs of persons who are experiencing chronic homelessness who have a substance use or co-occurring use and mental health disorder through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

### **PACT Teams**

Mississippi has eight Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto County), Region 6 (serves Leflore County), Region 9 (serves Hinds), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service

delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

### **Supported Employment**

The DMH utilized legislative appropriated community expansion general funds to provide 4 pilot program sites (Regions 2,7,10, and 12) to begin implementation of supported employment services for adults living with mental illness in Mississippi. The DMH will retain the consultative services of a nationally recognized expert in the development and implementation of sustainable Individual Placement and Supports Model (IPS) for Adult Mississippians living with mental illnesses. The DMH will collaborate with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental illness.

### **Older Adults**

The Division of Alzheimer's Disease and Other Dementia provides awareness activities and educational training programs for family caregivers, direct care workers and other professional service providers, information and referral, adult day service programs, and annual education conferences. In addition, the Division works in collaboration with other state and nonprofit agencies on a variety of programs and projects such as development and implementation of the State Strategic Plan for Alzheimer's Disease, law enforcement training, adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services.

The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets.

### **Intensive Community Support Service**

Intensive Community Support Services are a key part of the continuum of mental health services and supports for people with serious mental illness. Intensive Community Support Services promote independence and quality of life through the coordination of appropriate services and the provision of constant and on-going support as needed by the consumer. The direct involvement of the consumer and the development of a caring, supportive relationship between the Intensive Community Support Specialist and the consumer are integral components of the Intensive Community Support process. Intensive Community Support Services is responsive to consumers' multiple and changing needs, and plays a pivotal role in coordinating required services from across the mental health system as well as other service systems (i.e., criminal justice, developmental services, and addictions).

Intensive Community Support Services is more than a brokerage function. It is an intensive service that involves building a trusting relationship with the consumer and providing on-going support to help the consumer function in the least restrictive, most natural environment and achieve an improved quality of life and helping them to achieve their recovery goals.

The Intensive Community Support Specialist maintains involvement, as consumer needs change and cross service settings. The priority population for intensive case management services is

people who meet the definition for serious mental illness and require on-going and long-term support.

Intensive Community Support Services are distinguished from usual Community Support Services by:

- (a) Engagement in community settings of people with severe functional impairments traditionally managed in hospitals
- (c) An unusually low client to staff ratio
- (d) Multiple visits per week as needed (high intensity input)
- (e) Interventions primarily in the community rather than in office settings

Intensive Community Support Services is a comprehensive and complex service that involves:

- Outreach and Consumer Identification
- Assessment and Planning
- Direct Service Provision/Intervention
- Monitoring, Evaluation and Follow-up
- Information, Liaison, Advocacy, Consultation and Collaboration

Intensive Community Support Services are currently being offered at all 14 of our CMHC's.

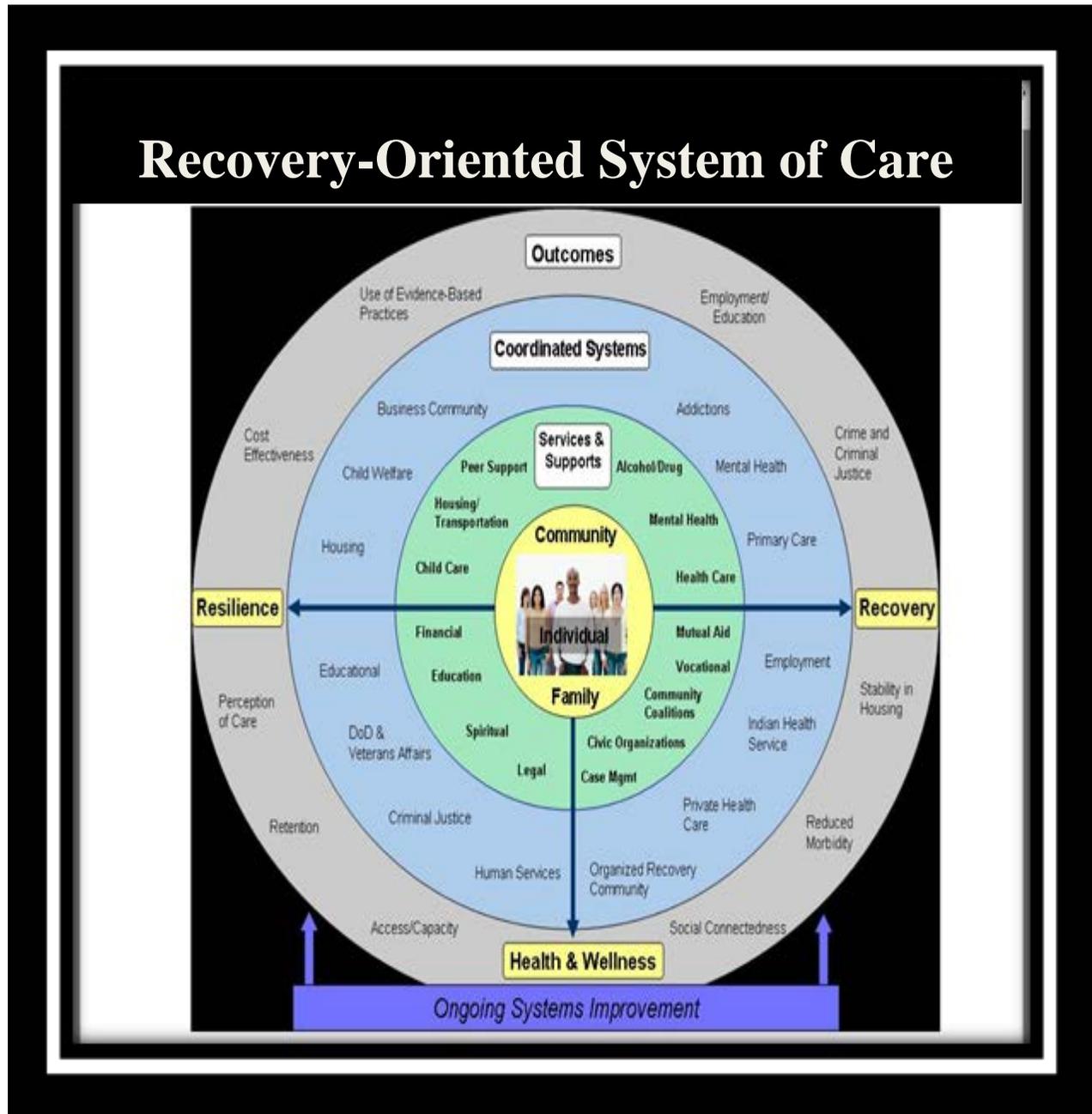
### **Psychosocial Rehabilitation Services (PSR)**

Psychosocial Rehabilitation Services consist of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

### **Recovery-Oriented System of Care**

The Recovery-Oriented System of Care model is designed to support individuals seeking to overcome mental health disorders and substance use disorders across their lifespan. There is no wrong door to recognize the recovery-oriented system of care needs to provide “genuine, free and independent choice” among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals. Individuals should also be able to access a comprehensive array of services that are fully coordinated to provide support to individuals. At the center of the system is the individual, community, and family. Several types of service options and activities may be included in the service components. A major change in the description of characteristics of the system has been made to reflect a philosophy shift to one that is more individualized. Strategies to evaluate and improve the effectiveness of local advisory councils, comprised of consumers and family members, have been included in system

improvement efforts. The service components of the Recovery-Oriented System of Care model include: consumer support services, outpatient services, crisis response services, community living options, identification and outreach, psychosocial rehabilitation services, supported employment, family/consumer education and support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance use are also included in the system of community-based care.



## Recovery Supports

The DMH Strategic Plan sets forth the DMH's vision of having individuals who receive services to have a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. Initiatives in the State Plan are designed to facilitate a system that is person-centered and built on the strengths of individuals and their families while meeting their needs for special services. The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 1 of the DMH Strategic Plan highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long term community supports and other specialized services. Goal 1 of the Strategic Plan also provides a foundation on which the DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

Recovery means something different to everyone. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one's disease(s) or symptoms, for example: abstaining from use of alcohol, illicit drugs, and non-prescribed medication if one has an addiction problem; and for everyone in recovery, making informed health choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society, *and*
- Community: relationships and social networks that provide support, friendship, love and hope

## Health Care and Health Systems Integration

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

The FY 2014-2015 State Plans for Community Mental Health and Alcohol and Services reflect the elements in the Department of Mental Health's 10-Year Strategic Plan which encompasses Integration of Behavioral Health and Primary Care Services, Recovery Supports, Provision of Services for Individuals with Co-Occurring Disorders, and Trauma.

Strategies designed to facilitate integration of mental illness and substance use are included in the Department's Plan (objectives to increase integration of primary and mental health care and to increase effectiveness of collaboration among community mental health providers, state agencies, governmental entities, and non-governmental entities). In 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care. IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc. Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care. Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association. Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue.

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

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

- The DMH Bureau of Alcohol and Drug Services work collaboratively with the MS Band of Choctaw Indians and continue to fund prevention services with Choctaw Behavioral Health.
- The DMH Bureau of Alcohol and Drug Service has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. Through this partnership, trainings are provided around the state. The training is also available for A&D personnel located at community mental health centers.
- The DMH Bureau of Community Services' Annual Provider Survey gathers self-reported information on integrated primary and behavioral health care, as well as on tele-medicine opportunities.
- In December 2014, the DMH Bureau of Community Services and the DMH Bureau of Outreach, Planning and Development applied for and were awarded membership in the SAMHSA-HRSA Center for Integrated Health Solution's (CIHS) Innovation Community entitled Building Integrated Behavioral Health in a Primary Care Setting. This collaboration is between the DMH, a local CMHC, and a local FQHC.
- In March 2015, the DMH Division of Recovery and Resiliency applied for and was awarded a 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Subcontract for the Expansion of Policy Academy Action Plans.

## **Trauma and Justice**

Most individuals seeking public health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse, and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders, HIV/AIDS, as well as contact with the criminal justice system. When programs take the step to become trauma-informed, every part of their organization, management, and service delivery system should be assessed and have a basic understanding of how trauma affects the lives of these individuals seeking services, the vulnerabilities, and/or triggers of trauma survivors.

The Mississippi Department of Mental Health, Bureau of Community Services and the Bureau of Alcohol and Drug Services are working collaboratively to provide training intended to address the effects of trauma. These trainings will be particularly helpful for adult and child survivors of abuse, disaster, crime, shelter populations, and others. It will be aimed at promoting relationships rather than focusing on the traumatic events in their lives. The trainings can also be utilized by first providers, frontline service providers and agency staff. Providers of children and youth mental health services in Mississippi are being trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). The Department of Mental Health, Division of Children and Youth Services is providing trauma-informed trainings to community and state partners including family members and caregivers.

Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need. In addition, the Department of Mental Health, Division of Children and Youth Services collaborates with the Division of Youth Services,

Department of Human Services to implement Adolescent Opportunity Programs (AOP) in eight (8) Community Mental Health Centers across the state. AOPs target adjudicated delinquent youth ages 12-17 years who are at high risk of becoming further involved in the criminal justice system. The DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide.

### **Relias Learning Website**

The Department of Mental Health provides Web-Based Training through Relias Learning for registered providers. Relias is a customized learning management system and staff development tool that offers evidenced – based practices training. The Relias Learning training website tracks staff training and eliminates the need for extensive travel to obtain training.

## **Criterion 2: Mental Health System Data Epidemiology**

### **Estimate of Prevalence**

#### **Children and Youth**

Mississippi utilized final methodology for estimating prevalence of serious emotional disturbance among children and adolescents, as published by the National Center for Mental Health Services (CMHS) in the July 17, 1998, issue of the *Federal Register*. The estimated number of children, ages 9–17 years in Mississippi in 2013 is 369,698. Mississippi remains in the group of states with the highest poverty rate (29.1% age 5–17 in poverty, based on 2013 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 2013 are as follows:

- Within the broad group (9–11%), Mississippi’s estimated prevalence range for children and adolescents, ages 9–17 years, is 11–13% or from 40,667 – 48,061.
- Within the more severe group (5–7%), Mississippi’s estimated prevalence range for children and adolescents, ages 9–17 years, is 7–9% or from 25,879 – 33,273.

For transitional age youth, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (139,463), yielding an estimated prevalence of 12,831 in this transition age group.

In FY 2014, 34,194 children with serious emotional disturbance were served through the public community mental health centers and other nonprofit providers of community services (*Mississippi State Plan for Community Mental Health Services Implementation Report*, FY 2014).

## **Adults**

Mississippi utilized the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the National Center for Mental Health Services in the June 24, 1999, issue of the *Federal Register*. The estimated number of adults in Mississippi, ages 18 years and above is 2,228,376 based on *U.S. Census 2013* 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 and above is 5.4 % or 120,332 in 2013.

In FY 2014, 59,300 adults with serious mental illness were served through the public community mental health system in Mississippi. Services were provided in all 14 mental health regions and by the community services division of one psychiatric hospital to 11,034 individuals with co-occurring disorders (*Mississippi State Plan for Community Mental Health Services*, FY 2014.)

The following tables show the number of adults (age 18 and above) and children (17 and below) Who received mental health services during the State FY periods indicated the tables:

State Fiscal Year	Under 18	18 and older
2012-2013	28,577	63,930
2013-2014	29281	59,300

## **Criterion 3: Children’s Services**

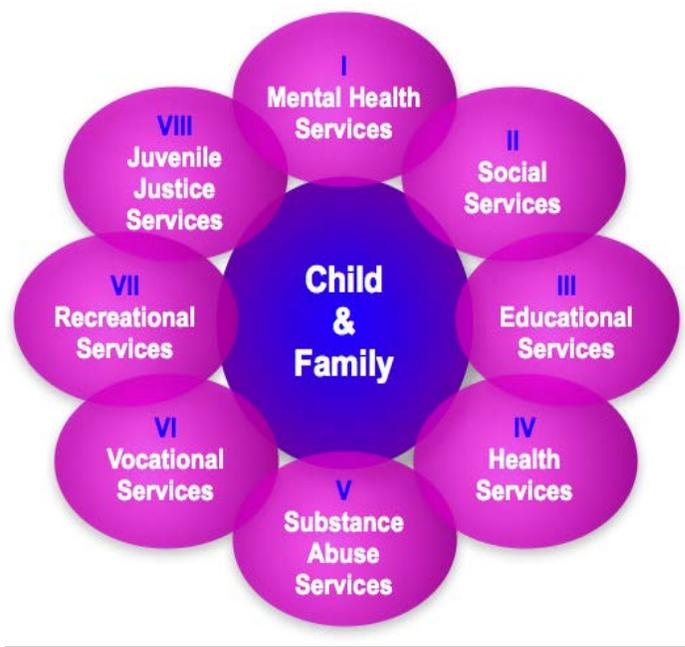
Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the current DSM and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. The need for mental health as well as other special needs services and support services is required by these children/youth and families at a more intense rate and for a longer period than children/youth with less severe emotional disorders/disturbance in order for them to meet the definition’s criteria.

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 14 regional mental health/mental retardation commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, intensive home/community-based services, family education and prevention/early intervention services. Public inpatient services are provided directly by the DMH (described further later under this criterion). The DMH remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State-Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Acute Inpatient Services, Mobile Crisis/Emergency Response Teams, Medication Maintenance, Intensive Home/Community Based Services, Wraparound Facilitation, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early Periodic Screening, Diagnosis and Treatment Program, funded by

the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group, and psychological and developmental evaluations.

### Mississippi's System of Care for Children and Youth

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



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

analyzing data and funding strategies, coordinating local MAP Teams, and applying for grants from public and private sources.

## **Interagency Collaboration for Children and Youth with SED**

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

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

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county human services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. This wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 14 community mental health regions across the state. Sixty three counties either have a MAP Team or access to one, and all 53 MAP Teams continue to operate statewide and have accessibility to flexible funds. In FY 2014, 1 DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. Currently, Sixty-three (63) counties either have a MAP Team or access to a MAP Team. All 53 MAP Teams continued to operate and had access to flexible funds. Region 8

continued to receive additional funding for children with Fetal Alcohol Spectrum Disorders. During FY 2014, MAP Teams served 1,504 children and youth

The Executive Steering Committee provides oversight and accountability of MTOP's activities toward meeting requirements of the Cooperative Agreement with the Substance Use and Mental Health Services Administration (SAMHSA). In addition to other tasks, this committee meets monthly and participates on the subcommittees of the Statewide Affinity Group, ensures that effective support and technical assistance are provided to the MTOP sites, votes on budget issues, and advocates on a youth's behalf or on behalf of other youth and families who may not have found their voice. Membership of the committee includes, but is not limited to, DMH representation, the local-level MTOP Project Coordinators, a representative from three family advocacy networks, a faith-based organization, a juvenile justice entity, the Attorney General's Office, the MS Department of Human Services, the MS Department of Education, the Department of Vocational Rehabilitation, a continuous quality improvement/evaluation entity, a post-secondary education entity, a community college representative, Certified Peer Support Specialist, two youth, and two family/parent representatives.

The DMH staff participates in a variety of state-level interagency collaboration activities and provides support for interagency collaboration at the local level in the 14 CMHC regions. These efforts involve staff of other key child service agencies or nonprofit organizations at the state and local levels and representatives of parent/family organizations for children with serious emotional disturbance. Notification of education/training activities offered by the DMH Division of Children and Youth Services will be distributed to programs serving runaway/homeless youth made known to the DMH through other child service agencies (primarily the Department of Human Services).

## **Provision of Evidence-Based Practices**

### **Wraparound Initiatives in Mississippi**

The Division of Children and Youth Services partnered with the Division of Medicaid's MYPAC Program to begin state-wide training on Wraparound Facilitation for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work for the Mississippi Wraparound Initiative (MWI). MWI has four national certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. In addition, the Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding the Chronic Stress (SPARCS) annually. In FY 2014, CMHC Regions 2, 3, 6, 8, and 9 and staff from the two DMH operated hospital units serving children and youth participated in a Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) Learning Community training 40 therapists, including 10 supervisors. Numerous DMH staff are certified trainers in Mental Health First Aid for Youth (MHFA-Y) and Applied Suicide Intervention Skills Training (A.S.I.S.T.), safe TALK, and Question, Refer and Persuade (QPR) as well. DMH trainers provide trainings upon requests to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. In FY 2014,

Division of Children and Youth Services staff completed 5 suicide awareness/A.S.I.S.T. trainings to members of Mobile Crisis Emergency Response Teams (MCeRT) operated by CMHC Regions 1, 2, 3, 6, 7, 8, 9, and 15. Two Division of Children and Youth staff continues to maintain their certification as A.S.I.S.T. Trainers. In March 2014, an additional staff member completed a week long training to become a certified A.S.I.S.T. Trainer.

## **Integrated Services for Children and Youth with SED**

### **Adolescent Offender Programs**

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

### **Initiatives to Assure Transition to Adult Mental Health Services**

The Division of Children and Youth Services, the Division of Adult Community Services, and the Bureau of Alcohol and Drug Services have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. The Transitional Services Task Force was formed to better identify and plan to assess needs of youth, age 16 to 25 years. This task force, now called the Executive Steering Committee, has focused on expanding the age range of children/youth identified as transitional—age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Committee includes representatives from a local mental health center that provide specialized outreach programs as well as representatives from the Division of Medicaid, the Office of the Attorney General and the DMH Bureau of Community Services. The Executive Steering Committee has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. The work of this committee and its members assisted in the development of successful grant applications for a Children's Mental Health Initiative targeting transition-aged youth. First, a 6-year System of Care grant that provides funds for the implementation of 3 additional Transitional Outreach Programs (MTO) across the state and most recently, a 4-year grant that expands MTO to 2 additional counties.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services of a provider of a transitional living services program that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. The DMH provides funding to 4 of the 6 DMH certified transitional therapeutic group homes (Rowland, Harden House, and 2 programs operated by Hope Village).

### **Youth Education/Support Initiatives**

Through MTO, each program site has developed Youth Leadership and Advocacy Councils. These councils meet on a regular basis to plan for fundraising events, community activities, various trainings and independent skill development. Members of these youth councils have attended and presented at national SOC grant meetings, the Georgetown Training Institutes, and FFCMH annual conferences and trainings.

### **Support for Services for Youth with Co-occurring Disorders**

The Division of Children and Youth Services and the Bureau of Alcohol and Drug Services collaborate to include sessions on co-occurring disorders in youth at the annual MS School for Addiction Professionals. The Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance use problems which also address problems of youth with co-occurring disorders.

### **Criterion 4: Targeted Services to Rural and Homeless Populations**

The DMH continues to support specialized services targeting individuals who are homeless and have mental illness in areas of the state where there are known to be large homeless populations with a significant number of individuals with mental illness and where the Projects for Assistance in Transition from Homelessness (PATH) funds would have the greatest impact (Jackson, Meridian, and the Gulf Coast).

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. Staff attend the MS United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings. The DMH continues to receive technical assistance in the implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program in Mississippi as provided by SAMHSA. The purpose of SOAR is to help states increase access to mainstream benefits for individuals who are homeless or at risk for homelessness through specialized training, technical assistance, and strategic planning for staff that provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process. While 6 DMH or service provider staff have completed the SOAR Train the Trainer process and have in turn trained a number of service providers in the SOAR method in the past, the SOAR training is now available online. The DMH provides information and oversight regarding the online training. There is an online SOAR data collection system that SOAR processors in the state are encouraged to use to report the results of the SSI/SSDI applications that are submitted using SOAR.

### **Criterion 5: Management Systems**

Federal Block Grant Award 7/1/2014 – 6/30/2015	
Administration Amount	\$4,215,406.00
Set Aside	\$200,734.00
Amount to be awarded	\$3,803,902.00
Children's portion	\$1,559,599.82
Adult portion	\$2,244,302.18

## Identification of the Unmet Service Needs and Critical Gaps for Adults and Children

The Mississippi Board of Mental Health and the DMH developed a Strategic Plan five years ago. The Strategic Plan was developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan was to create a living, breathing document. The Plan was developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies. The DMH wanted to make strides toward developing a community-based service system which focuses on evidence-based practices and improves access to care.

The Bureau of Community Services used the report published by *Mental Health America Parity or Disparity: The State of Mental Health in America 2015*, to assist us in identifying gaps in our services for adults and children. The report identifies indicators available across all fifty states and the District of Columbia. The report is organized in general categories relating to mental health status and access to mental health services. The data allows the DMH to see how our state is ranked among the other states.

- 51<sup>st</sup> for Adults with highest prevalence of mental illness and lowest rates of access to care
- 45<sup>th</sup> for Adults with any mental illness
- 28<sup>th</sup> for Adults with serious thoughts of suicide
- 50<sup>th</sup> for Adults any mental illness and uninsured
- 51<sup>st</sup> for Adults with Disability who could not see a Doctor due to costs
- 46<sup>th</sup> in mental health workforce availability

The DMH receives feedback through the review of the State Plan by the Mississippi State Mental Health Planning and Advisory Council and the Mississippi Board of Mental Health. The DMH has also benefited greatly from the continuity of its relationship with the Mississippi State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH sends out a statewide satisfaction survey for adults and children as another means of collecting feedback from individuals served by the system. Family members, consumers, local service providers, and representatives from other agencies participate on numerous task forces and coalitions.

In addition to considering estimates of prevalence for targeted groups, results of a statewide consumer survey, public forums, and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing were identified. As part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided the DMH with state level population data and various indicators of poverty and disability. While there continues to be a need for transportation and housing for targeted groups, the information and data provided by TAC has been used on occasions to educate public officials, stakeholders, and funding sources regarding the need for expanding and increasing transportation and housing. The TAC data has also been used to develop applications for funding to increase these services.

The DMH management staff receives regular reports from the Division of Office of Consumer Support (OCS), which tracks requests for services by major category, as well as receives and

attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system.

The Division of Children and Youth Services gains information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, and through the work of the State-Level Interagency Case Review Team, two SAMHSA funded initiatives, and the Mississippi Transitional Outreach Program described in more detail in the State Plan.

According to the Behavioral Health Barometer, Mississippi 2014 Report, approximately 18,000 adolescents (7.6% of all adolescents) per year in 2009-2013 had at least one Major Depressive Episode (MDE). Approximately 6,000 adolescents with MDE (33.8% of all adolescents with MDE) per year in 2009-2013 received treatment for their depression.

In the Mental Health America Report, Parity or Disparity: The State of Mental Health in America 2015, the following information is reported on Mississippi's rankings compared to other States:

- 42<sup>nd</sup> for Youth ranking with the highest prevalence of mental illness and lowest rates of access to care
- 47<sup>th</sup> for children with emotional, behavioral and developmental issues
- 12<sup>th</sup> for youth with at least one Major Depressive Episode
- 41<sup>st</sup> for youth who attempted suicide
- 43<sup>rd</sup> for children with emotional, behavioral, and developmental issues who were consistently insured
- 46<sup>th</sup> for children who needed but did not get mental health services
- 31<sup>st</sup> for children reporting inadequate insurance
- 46<sup>th</sup> in mental health workforce availability

The 2013 Youth Risk Behavior Survey reports the following information related to violence, attempted suicides, alcohol and drug use, and risky sexual behavior:

- The percentage of students who carried a gun on one or more of the past 30 days increased (7.8% in 2001 and 11.6% in 2013), however the percentage of students who carried a weapon such as a gun, knife, or club on school property decreased (6.5% in 2001 and 4.1% in 2013).
- The percentage of students who were bullied on school property during the last 12 months increased from 16% in 2009 to 19.2% in 2013 which relates to the increase of students who felt unsafe at school (6.9% in 2009 and 8.3% in 2013).
- The percentage of students who actually attempted suicide one or more times during the past 12 months increased from 6.3% in 2009 to 10.9% in 2013.

Access to care is an identified challenge for Mississippi's youth based on the high prevalence rate of emotional and behavioral issues. The DMH has worked diligently to increase the number of qualified providers and to expand services/programs across the State. Two new providers have been certified by DMH to provide the Core Services for adults and children/youth. Five providers have expanded their services to include intensive home and community based services (MYPAC) which utilize wraparound facilitation, crisis intervention, and community support

services. DMH is collaborating with the University of Southern Mississippi and the Division of Medicaid to implement high-fidelity wraparound facilitation to those children and youth with serious emotional/behavior disorders and involved in more than one child-serving system.

The DMH has created the Division of Crisis Response to address the development of crisis response capabilities in the state. The Division of Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs) which provide 24-hour a day face-to-face or telephone crisis response depending on the nature of the crisis. MCeRTs assess adults and children with mental illness, substance use, and intellectual and developmental disabilities. MCeRTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.

The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. MCeRTs assess adults and children with mental illness, substance use, and intellectual and developmental disabilities. MCeRTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.

The DMH, Division of Children and Youth Services has consistently provided Mental Health First Aid for Youth training to organizations including schools that request training. The DMH also provides Applied Suicide Intervention Skills Training (ASIST) to all MCeRTs and other child-serving professionals on a regular basis. MCeRTs are available across the State to respond to mental health crisis in the school, community programs, detention centers, and homes. The Office of Consumer Support is responsible for maintaining a 24-hour, 7-days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide Prevention Lifeline. The Office of Consumer Support responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.

The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.

The Bureau of Outreach, Planning and Development coordinates the Peer Support Specialist Program. This program is designed to promote the provision of quality Peer Support Services and to enhance employment opportunities for individuals with serious mental illness and substance use. Certified Peer Support Specialists are required by the DMH to be an integral component of PACT and MCeRT.

### Step 3: Prioritization of State Planning Activities

**Table 2 Plan Year FY 2016-2017:**

Priority Areas	
1	Peer Support
2	Community Supports for Adults
3	Crisis Services
4	Supported Housing
5	Community Supports for Children
6	Community Integration
7	Supported Employment
8	Recovery Supports

### Step 4: Objectives, Strategies and Performance Indicators

The primary target populations addressed in the FY 2016-2017 State Plan are children with serious emotional disturbances (SED) and adults with serious mental illness (SMI).

**\*The following goals are not exclusively funded by federal block grant dollars.**

<b>Priority Area 1</b>	Peer Support
<b>Priority Type</b>	MHS
<b>Population</b>	SMI, SED
<b>Goal 1</b>	Enhance the transition process of individuals to a less restrictive environment
<b>Objective 1</b>	Establish a pilot utilizing Peer Bridgers to improve the process for people transitioning from inpatient care to community-based care
<b>Strategies</b>	Begin a pilot project with Peer Bridgers at a behavioral health program and local Community Mental Health Centers utilizing WRAP and Whole Health Action Management (WHAM)
<b>Indicator</b>	Number of Peer Bridgers
<b>Baseline Measurement</b>	In FY 2015: 0 (this is a Pilot Project)
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 4
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 7
<b>Description of Data</b>	Number of Peer Bridgers employed by Pilot Project

<b>Priority Area 1</b>	Peer Support
<b>Priority Type</b>	MHS
<b>Population</b>	SMI, SED
<b>Goal 2</b>	Utilize peers and family members to provide varying supports to assist individuals in regaining control of their lives and their own recovery

	process
<b>Objective 1</b>	Increase the number of Certified Peer Support Specialists (CPSS)
<b>Strategies</b>	<ul style="list-style-type: none"> <li>• Conduct outreach to stakeholders to increase the number of CPSS and the role of CPSSs</li> <li>• Provide training to service providers regarding Recovery Model, Person Centered Planning &amp; System of Care Principals, etc</li> <li>• Offer technical assistance to providers after their POM report is released</li> <li>• Establish a CPSS customized training for caregivers/parents</li> </ul>
<b>Indicator</b>	Number of CPSSs employed by DMH certified providers
<b>Baseline Measurement</b>	In FY 2015: 125
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 155
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 175
<b>Description of Data</b>	Number of CPSS who complete training and become employed by the DMH certified providers

<b>Priority Area 2</b>	Community Supports for Adults
<b>Priority Type</b>	MHS
<b>Population</b>	SMI
<b>Goal 1</b>	Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements
<b>Objective 1</b>	Utilize Programs of Assertive Community Treatment (PACT) Teams to help individuals who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient services
<b>Strategies</b>	Increase the number of admissions of PACT Teams
<b>Indicator</b>	Number of admissions to PACT Teams
<b>Baseline Measurement</b>	In FY 2015: 97
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 250
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 275
<b>Description of Data</b>	Number of individuals admitted to PACT Teams.

<b>Priority Area 2</b>	Community Supports for Adults
<b>Priority Type</b>	MHS
<b>Population</b>	SMI
<b>Goal 2</b>	Provide funding to offset cost of mental health services provided to

	individuals with serious mental illness who have no payer source
<b>Objective 2</b>	Provide services through the Purchase of Services Grant
<b>Strategies</b>	Grant funding to 14 CMHCs for Purchase of Services
<b>Indicator</b>	Number of units of service reimbursed by Purchase of Service Grant
<b>Baseline Measurement</b>	In FY 2015: 180,002
<b>First Year Target/Outcome Measurement</b>	In FY 2016: Maintain or increase the number of units of service
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: Maintain or increase the number of units of service
<b>Description of Data</b>	Grant awards/monthly cash requests

<b>Priority Area 3</b>	Crisis Services
<b>Priority Type</b>	MHS
<b>Population</b>	SMI, SED
<b>Goal 1</b>	Expand access to crisis services through the utilization of Mobile Crisis Response Teams
<b>Objective 1</b>	Expand access to crisis services and divert individuals from more restrictive environments such as jails, hospitals, etc.
<b>Strategies</b>	Increase the number of contacts made by the Mobile Crisis Response Teams
<b>Indicator</b>	Number of Contacts
<b>Baseline Measurement</b>	In FY 2015: 19,660
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 20,000
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 20,500
<b>Description of Data</b>	Number of Contacts

<b>Priority Area 3</b>	Crisis Services
<b>Priority Type</b>	MHS
<b>Population</b>	SMI, SED
<b>Goal 1</b>	Expand access to crisis services and divert from more restrictive environments such as jails, hospitals, etc.
<b>Objective 2</b>	Expand access to crisis services through the utilization of Crisis Stabilization Units
<b>Strategies</b>	Increase the number of admissions to the Crisis Stabilization Units
<b>Indicator</b>	Number of Admissions
<b>Baseline Measurement</b>	In FY 2015: 3,609

<b>First Year Target/Outcome Measurement</b>	In FY 2016: 3,800
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 4,000
<b>Description of Data</b>	Number of involuntary and voluntary admissions

<b>Priority Area 4</b>	Supported Housing
<b>Priority Type</b>	MHS
<b>Population</b>	SMI
<b>Goal 1</b>	Provide community supports for people transitioning to the community to allow adults with serious mental illness access to appropriate and affordable housing
<b>Objective 1</b>	Increase the availability of community supports/services for people with a serious mental illness in order to implement the Permanent Supportive Housing model
<b>Strategies</b>	Ensure that people with a serious mental illness who are housed as a result of the Permanent Supportive Housing have the opportunity to live in the most integrated settings in the community of their choice by providing an adequate array of community supports/services
<b>Indicator</b>	Number of assessments provided Number and type of supports/services provided Number of people maintained in permanent supportive housing
<b>Baseline Measurement</b>	In FY 2015: 0 (Number of adults with SMI receiving permanent housing will be gathered by FY 2016)
<b>First Year Target/Outcome Measurement</b>	In FY 2016: Increase number by 5%
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: Increase number by 10%
<b>Description of Data</b>	Number of assessments provided, number of supports/services provided, number of people maintained in Permanent Supportive Housing

<b>Priority Area 5</b>	Community Support for Children
<b>Priority Type</b>	MHS
<b>Population</b>	SED
<b>Goal 1</b>	Utilize MAP Teams to help serve children and youth in their community and prevent unnecessary institutionalizations
<b>Objective 1</b>	Increase the number of children and youth served by MAP Teams
<b>Strategies</b>	Technical assistance will be provided to MAP Teams as requested and/or needed.
<b>Indicator</b>	Number served by MAP Teams
<b>Baseline</b>	In FY 2015: 1,079

<b>Measurement</b>	
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 1,011
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 1,200
<b>Description of Data</b>	Number served by MAP Teams

<b>Priority Area 5</b>	Community Supports for Children
<b>Priority Type</b>	MHS
<b>Population</b>	SED
<b>Goal 2</b>	Increase statewide use of Wraparound Facilitation with children and youth
<b>Objective 2</b>	Increase the number of children served by Wraparound Facilitation
<b>Strategies</b>	Increase statewide use of wraparound facilitation with children and youth
<b>Indicator</b>	Number of children served by Wraparound Facilitation
<b>Baseline Measurement</b>	FY 2015: 1,078
<b>First Year Target/Outcome Measurement</b>	FY 2016: 1,011
<b>Second Year Target/Outcome Measurement</b>	FY 2017: 1,200
<b>Description of Data</b>	Number of children served by Wraparound Facilitation

<b>Priority Area 5</b>	Community Supports for Children
<b>Priority Type</b>	MHS
<b>Population</b>	SED
<b>Goal 3</b>	Assist youth and young adults in navigating the road to recovery from an episode of psychosis, including efforts to function well at home, on the job, at school and in the community through the Coordinated Specialty Care Team
<b>Objective 1</b>	Increase the number of youth and young adults served through the NAVIGATE Program.
<b>Strategies</b>	Pilot an evidenced based intervention program for youth and young adults who have experienced first episode of psychosis
<b>Indicator</b>	Number of youth and young adults served through the NAVIGATE Program
<b>Baseline Measurement</b>	In FY 2015: Data collected
<b>First Year Target/Outcome</b>	In FY 2016: Increase by 5%

<b>Measurement</b>	
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: Increase by 10%
<b>Description of Data</b>	Numbers served

<b>Priority Area 6</b>	Community Integration
<b>Priority Type</b>	SAT, MHS
<b>Population</b>	SMI
<b>Goal 1</b>	Divert individuals from DMH Behavioral health Programs chemical dependency services waiting lists to community-based programs by providing education to chancery courts and providing indigent funds for those individuals in need
<b>Objective 1</b>	Increase the number of individuals diverted from DMH Behavioral Health Programs wait lists to community-based programs
<b>Strategies</b>	<ul style="list-style-type: none"> <li>• Provide bi-monthly reports of contact information of individuals on the DMH Behavioral Health Programs chemical dependency waiting list from each regional catchment area to the regional community mental health center's alcohol and drug treatment programs</li> <li>• Provide education to chancery courts about community-based program services for committed individuals for alcohol and drug treatment programs</li> </ul>
<b>Indicator</b>	Number of individuals diverted from DMH Behavioral Health Programs wait lists to community-based programs
<b>Baseline Measurement</b>	In FY 2015: 110
<b>First Year Target/Outcome Measurement</b>	In FY 2016: Increase by 10%
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: Increase by 15%
<b>Description of Data</b>	Number of individuals diverted from DMH Behavioral Health Program wait lists to community-based programs

<b>Priority Area 7</b>	Supported Employment
<b>Priority Type</b>	MHS
<b>Population</b>	SMI
<b>Goal 1</b>	Develop employment options for adults with serious and persistent mental illness
<b>Objective 1</b>	Increase the number of individuals who are gainfully employed
<b>Strategies</b>	<ul style="list-style-type: none"> <li>• Legislative appropriated community expansion general funds will be utilized to provide 4 pilot program sites to begin implementation of supported employment services for adults living with mental illness.</li> </ul>

	<ul style="list-style-type: none"> <li>• Collaboration with Vocational Rehabilitation Services will take place.</li> </ul>
<b>Indicator</b>	The number of individuals who are gainfully employed
<b>Baseline Measurement</b>	In FY 2015: Baseline Gathered
<b>First Year Target/Outcome Measurement</b>	In FY 2016: 75
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: 80
<b>Description of Data</b>	Individuals who are gainfully employed

<b>Priority Area 8</b>	Recovery Supports
<b>Priority Type</b>	MHS,
<b>Population</b>	SMI, SED
<b>Goal 1</b>	Strengthen family education and family support capabilities in the state
<b>Objective 1</b>	Increase recovery supports to people through family education and family support provided y NAMI-MS funded by DMH
<b>Strategies</b>	Provide a variety of training and workshops targeting people with SMI and family members throughout the state
<b>Indicator</b>	Number of training and workshops
<b>Baseline Measurement</b>	In 2015: 110 workshops/support groups/trainings for NAMI
<b>First Year Target/Outcome Measurement</b>	In 2016: Increase trainings/workshops by 5%
<b>Second Year Target/Outcome Measurement</b>	In 2017: Increase trainings/workshops by 10%
<b>Description of Data</b>	Number of trainings and workshops

<b>Priority Area 8</b>	Recovery Supports
<b>Priority Type</b>	MHS, SED
<b>Population</b>	SMI
<b>Goal 2</b>	Expand the peer review/quality assurance process by utilizing Personal Outcome Measures (POM) interviews to measure outcomes of individuals receiving services
<b>Objective 1</b>	Improve access and outcomes of services to people receiving services through data gathered in POM interviews
<b>Strategies</b>	Offer technical assistance to providers after POM reports are released
<b>Indicator</b>	Increase by 5% two POMs that directly support community integration
<b>Baseline Measurement</b>	In FY 2015: gather baseline
<b>First Year</b>	In FY 2016: Increase by 5% two community integration POMs

<b>Target/Outcome Measurement</b>	
<b>Second Year Target/Outcome Measurement</b>	In FY 2017: Increase by 5% two POMS in another focus area to be determined in FY 2016
<b>Description of Data</b>	Increase by 5% in POM reports

# **SECTION III**

# **PLANNED EXPENDITURES**

**Table 2 State Agency Planned Expenditures**

<b>Activity</b>	<b>Substance Abuse Block Grant</b>	<b>Mental Health Block Grant</b>	<b>Medicaid (Federal, State, and Local)</b>	<b>Other Federal Funds (e.g., ACF(TANF), CDC, CMS (Medicare, SAMHSA, etc.)</b>	<b>State Funds</b>	<b>Local Funds (excluding local Medicaid)</b>	<b>Other</b>
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care		7,582,696.00		40,009,814.00	53,310,230.00		6,700.00

8. Mental Health Primary Prevention							
9. Evidenced Based practices for Early Intervention (5% of the state's total MHBG award)		420,149.00					
10. Administration (Excluding Program and Provider Level)		400,143.00					
11. Total	0	8,402,988.00	0	40,009,814.00	53,310,230.00	0	6,700.00

# **SECTION IV**

# **NARRATIVE PLAN**

## **1. Health Care System and Integration**

Beginning in 2009, the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care has been included in the DMH Strategic Plan. From 2010-2012, the DMH actively participated on the MS Department of Health's Patient-Centered Medical Home Advisory Committee. The Advisory Committee was charged with development of guidelines for Patient-Centered Medical Homes as per House Bill 1192 (2010 Regular Session of the MS State Legislature). Final guidelines were issued on September 25, 2012 (with an amendment dated October 31, 2012). The DMH Executive staff members participated in a State Health Summit held in August 2012 which was hosted by the Dr. Mary Currier, MS State Health Official. One area of focus was on the integration of behavioral health services. The DMH has continued to participate in the Mississippi Health Summit each year, most recently in May 2015.

In 2011, the DMH formed an Integration Work Group (IWG) to develop strategies to facilitate integration of primary and MI/IDD/AD services. Membership has continued to grow and expand each year. In 2015, current membership includes: individuals representing adult mental health services, children/youth mental health services, alcohol and substance use services, intellectual and developmental disability services, Alzheimer's/dementia services, community services programs, nursing, the DMH medical director, representatives from the MS Association of Community Mental Health Centers, the MS State Department of Health, community mental health center representatives and representatives of local federally qualified health centers. By June 30, 2012, the IWG had developed a Baseline Document of all known integrated services within the state mental health system. This Baseline Document is updated annually with information submitted in response to an annual Community Services Survey. Information from the Baseline Document was first shared at a statewide conference in October 2012. Since then, DMH and the IWG has embarked on a multi-agency effort to socialize integrated care concepts by making presentations at a number of statewide conferences, including the 2013 Biennial MS State Department of Health Conference, the 2014 Annual MS Association of Community Mental Health Centers Conference, the 2014 Annual MH/AIDD Conference, the 2015 Biennial MS State Department of Health Conference and the 2015 Annual Conference for the MS Primary Health Care Association. Throughout 2014-2015, DMH also included MS State Department of Health presentations on the Chronic Disease Self-Management Model at all DMH conferences. In both 2013 and 2015, the MS State Department of Health invited DMH to partner with them to develop conference content which included a full Behavioral Health track.

The DMH and the IWG have actively collaborated with other organizations and state agencies on potential projects and grant opportunities. These collaborative partners include the MS Primary Health Care Association, the MS Rural Health Association, the MS Association of Community Mental Health Centers, the Division of Medicaid, the Mississippi State Department of Health, Pine Belt Mental Healthcare Resources, Warren-Yazoo Mental Health Services, the University of Southern Mississippi, the University of Mississippi Medical Center and various Community Health Centers (FQHCs). In addition, DMH has actively pursued technical assistance available through the SAMHSA/HRSA Center for Integrated Health Solutions (CIHS). In 2014, DMH submitted an application to CIHS for participation in an Innovation Community entitled, Building Integrated Behavioral Health in a Primary Care Setting. DMH was awarded membership in this prestigious learning collaborative. In order to participate fully, DMH is overseeing two Case Studies: one with Jackson-Hinds Comprehensive Health Center (FQHC); and the second with Hinds Behavioral Health Services (CMHC). Both programs are working to provide integrated care services. The IWG serves as the Core Implementation Team for the project. Participation in the CIHS Innovation Community will conclude in August 2015.

In 2010, the MS Division of Medicaid applied for and received planning funding for development of a State Plan Amendment for Health Homes. Medicaid did receive planning funds for development of this SPA but, to date, no further information is available. There has been no collaboration with the DMH concerning this planning project. However, DMH plans to seek collaboration with the Division of Medicaid in consideration of an application for SAMHSA's Planning Grant for Certified Community Behavioral Health Clinics (application deadline of August 5, 2015).

The DMH has worked collaboratively with a number of other entities to develop initiatives for funding through various grant opportunities. In 2011, the DMH submitted a SAMHSA/NASMHPD Transformation Transfer Initiative (TTI) grant application entitled *Mississippi Health Integration Readiness Initiative*. This initiative included funding for assessment activities and for a statewide Summit on Behavioral Health and Primary Care Integration. It was not selected for an award. Also in 2011 and early 2012, the DMH partnered with the University of MS Medical Center to submit a CMS Health Care Innovation Challenge Grant entitled *MS Health Linkages Expansion Project*. It would have expanded UMC's existing Tele-Health Network, including Community Mental Health Centers. It was not selected for an award. In 2012 and again in 2015, the DMH actively promoted SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) grant. Submitted applications would have provided for primary care services to be made available through the Community Mental Health Centers, in most cases, through collaboration with the local Community Health Centers (FQHCs). Although several Community Mental Health Centers submitted applications each time, none of them were funded. Although none of these grant applications were successful, the opportunities for collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities.

The DMH is actively supporting a program at the University of Southern Mississippi's School of Social Work to expand behavioral health delivery capacity in primary care settings. Social Work and Psychology students are placed in Coastal Family Health (FQHC) and in field offices to provide direct services and coordinate care. Also, a professional development model for training for integrated care and a Training Institute will be developed. This program is funded through British Petroleum (BP) funding.

In March 2013, the DMH hosted a Spring Symposium entitled *Improving Quality of Life through Integrating Primary Care and Behavioral Health*. This day-long event was an effort to reach Physicians, Psychiatrists, Nurse Practitioners, Physician Assistants and Psychologists with information concerning the integration of primary, mental health and addiction services.

The DMH has funded the development of eight PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). The DMH requested additional funding from the MS State Legislature in 2012. Subsequently, DMH received special funding for four additional PACT Teams in FY15. Additionally, MS Medicaid provided the DMH with Balance Incentive Program (BIP) funding which supported the development of two additional PACT Teams in FY15. The DMH plans to continue to request additional funds.

The DMH is also a key participant with the Gulf Region Health Outreach Program's Primary Care Capacity Project. This program is funded by British Petroleum (BP). The purpose of this project is to strengthen healthcare in Gulf Coast communities in Mississippi, as well as in Louisiana, Alabama and the Florida panhandle. Still in its early stages, this project provides the DMH with an opportunity to highlight the need for incorporation of behavioral health and patient-centered care.

Collaboration continues between the DMH, the MS Office of Tobacco Control, the MS Department of Rehabilitation and the University of Southern Mississippi's Institute for Disability Studies to minimize the usage of tobacco products in Mississippi. Thanks, in part, to this collaboration, use of tobacco products among younger Mississippians is at historic lows.

The DMH has partnered with the MS Office of Tobacco Control to develop a tobacco utilization survey for use with mental health services consumers and alcohol and drug treatment facilities statewide. Its purpose is to better understand at what age a person is likely to smoke and what variables are in place to trigger first-time use. The survey will also collect data which will be used to identify the characteristics of tobacco users, the frequency of tobacco use, and how staff members can deliver alcohol and drug cessation and prevention services.

In addition, the DMH is working with the MS Office of Tobacco Control to develop public education materials about tobacco prevention to place in waiting rooms and in group therapy rooms. Plans are also in the early stages to develop a Policy Academy to address tobacco cessation among individuals with mental illness and/or addictions.

Health information is obtained for all individuals seeking services from the DMH certified providers on the Initial Assessment. A medical examination is required for individuals in supervised and residential programs, as well as in senior psychosocial programs. Also, Certified Peer Support Specialists are trained to assist individuals receiving services in accessing all health care services. Presently, integrated mental health, substance use and primary health care services are not all available at the same location on a statewide basis. Seven Community Mental Health Center regions report being equipped for Tele-Health services; six of the regions utilize Tele-Health to provide services such as psychiatric evaluations and medication monitoring. Four Community Mental Health Centers report working directly with their local Community Health Center to provide primary care and other medical services; two of those Community Mental Health Centers have a formal agreement with the Community Health Center. One Community Mental Health Center reports that they provide primary health care services at the CMHC. Region 3 Mental Health Center located in Tupelo, Mississippi, serves seven counties and is a comprehensive health system. As with all CMHCs in the state, Region 3 offers a complete array of mental health and substance use services for SMI Adults and SED children/adolescents. In March 2014, Region 3 opened a new ten thousand square foot building devoted to the co-location and integration of primary health care and behavioral health care services. Included in this facility is a pharmacy which provides both medical and psychotropic medication for all its clients. Additionally, Region 3 operates a mobile primary care unit which travels to four counties in its region.

## **2. Health Disparities**

The Cultural Competency Plan Implementation Workgroup recommended inclusion of language and proficiency in the DMH data collection standards including questions regarding primary language spoken by the individual, language preferred by the individual, language written by the individual, and whether or not the individual receiving services needed an interpreter. Due to funding constraints, the Workgroup was informed that additional questions to the current data collection system are currently not possible. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible. At present, the Department of Mental Health is not collecting data on the LGBTQ population. When cultural competency trainings are conducted in the state, the Cultural and Linguistic Competency Training Evaluation form includes a sexual orientation question. The data from the form is placed in a comprehensive report for the training results. The DMH Central Data Repository collects profiles of persons served in the public mental

health system including age, gender, and race/ethnicity. Services received, income, educational attainment and mode of pay can also be collected.

The current DMH Central Data Repository does not address or track language needs. Language needs are addressed by creating a comprehensive list of translators and interpreters in Mississippi as well as a list of resources for alternate forms of communication for individuals with hearing, visual and/ or other disabilities. These two lists have been mailed to programs to assist with providing language needs. The DMH Operational Standards Rule 14.3 A-F Cultural Competency/Limited English Proficiency Services align with the mandated standards (4-7) in the 2012 CLAS Standards (National Standards on Culturally and Linguistically Appropriate Services) from the Office of Minority Health. The CLAS mandates (4-7) are current federal requirements for all recipients of federal funds.

Hiring a skilled evaluator to monitor access, service use and outcomes would be helpful in reducing disparities. Reviewing the national disparities that exist in the system and comparing them to the disparities currently existing in Mississippi would also be helpful. Mississippi began work on the development of a survey for service providers asking them to identify what disparities exist in their community.

#### **4. Prevention for Serious Mental Illness**

In FY13 DMH used some of the British Petroleum grant monies to certify approximately 10 DMH staff as trainers in Mental Health First Aid (MHFA). These trainers have provided much training throughout the state in FY14 & FY15. The DMH staff has trained staff from the MS Department of Education, including local school districts, local police precincts, the MS Department of Rehabilitation Services and the CMHC mobile crisis response teams at each of the 14 CMHC regions. MHFA training will continue to enhance the progress that has already been made. Communities who have a better understanding of mental health issues are shown to display less stigma around mental illness. Hopefully, with more community understanding, those who suffer from mental illness will receive assistance and support from our schools, churches and the general public. The DMH will continue to provide this service in FY16.

#### **5. Evidence-Based Practices for Early Intervention (5 Percent)**

In its FY 2014 appropriation, SAMHSA was directed to require that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age. *Recovery After an Initial Schizophrenia Episode (RAISE)* initiative<sup>76</sup> SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded <sup>77</sup>, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity. States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles

identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented. It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. States should be reviewing their data collection efforts related to demonstrating the effectiveness of the programs for the targeted population. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting. Describe the state's assessed need for the target population and proposed evidence-based programs; provide an explanation for why this population was chosen, a description of planned activities, and a budget showing how the set-aside will be spent.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.).
2. Describe the evidence-based programs using the set-aside.
3. Are there alternative uses of the funds other than EBP's (i.e. staff development, regional plan, etc.) to support this required funding?
4. Describe the data collection efforts being used to demonstrate the effectiveness of the programs for this targeted population.

The Department of Mental Health subgranted Mississippi's portion of the five percent set aside to Community Mental Health Center Region 6/Life Help. Life Help, the largest Community Mental Health Center in the state serves 12 of 82 counties where 47.1% of children are in poverty. Approximately, 15% of the population in this region is ages 15-24 years of age, making this a priority group for early intervention. The target population for this initiative is youth/young adults ages 15- 30 years of age who have experienced a first episode of psychosis inclusive of diagnosis in the schizophrenia spectrum and other psychotic disorders. During FY 2014, a Coordinated Specialty Care Team was identified and trained using the NAVIGATE program that was created under the RAISE initiative. DMH contracted with NAVIGATE consultants, Susan Gingerich, Dr. Shirley Glynn, and Dr. Delbert Robinson to provide training and technical assistance to the CSC team. Two on-site trainings were provided to learn about the roles of the individual team members: Team Leader, Prescriber, Individual Resiliency Trainer, Family Education Clinician, Supported Employment and Education Specialist and Case Manager. The NAVIGATE consultant team continues to provide bi-monthly technical assistance phone calls to review roles, manuals, discuss youth referred, provide input and guidance on further program development. The CRC is actively serving three (3) young adults who are being seen several times throughout the week, invited to come to group meetings, social outings, and connected to other resources in the community. CSC Team education and meetings are held every other week, with the goal of obtaining one (1) referral each month for for FY 2015. Ongoing training, education and outreach to referral sources continue each month. Program specific data collection and measurements are under development. A NAVIGATE satisfaction survey will be administered quarterly to individuals in the program.

## **7. Program Integrity**

Specific grant requirements are conveyed to Department of Mental Health service providers during the RFP process. Additionally, service providers are required to sign a packet of applicable agreements including both a list of "Federal Assurances" and Mississippi Department of Mental Health Assurances on an annual basis. Any additional requirements specific to grant funding are included in this annual packet to be signed by the program administrator annually.

Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not

meet the programmatic intention of the grant funds or do not meet the “necessary and reasonable” test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise.

The Mississippi Department of Mental Health operates on a reimbursement payment system. Cash requests are submitted monthly by sub-grant recipients with specific items requested by category (salaries/fringe, contractual, commodities, equipment) for reimbursement. These requests are reviewed by grants management staff, accounts payable staff, and programmatic staff to insure items requested to be reimbursed are within the approved budget justification. The state accounting system prevents any service provider from being paid in excess of their budget award.

The Department of Mental Health has an Audit Division with two major functions:

- 1) Conduct annual compliance audits of grant sub-recipients. Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc. Audit procedures are outlined in the agencies “Central Office Audit Guide.”
- 2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines, reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies “Service Providers Manual” that is available on-line on the Mississippi Department of Mental Health website.

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## **8. Tribes**

The Division of Children and Youth Services provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding the Chronic Stress (SPARCS). This collaborative learning approach targets clinical/supervisory staff for intensive training in TF-CBT and SPARCS, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. Participants in the collaboratives have included clinicians from the 14 CMHCs and the MS Band of Choctaw Indians Behavioral Health. The Department of Mental Health continues to have an individual from the Choctaw Tribe participating on the Multicultural Task Force. The representative receives all correspondence related to the Multicultural Task Force. Staff from the Division of Children and Youth collaborated with a member from the Choctaw tribe about the 10th Annual Youth Leadership Conference that took place June 24-24, 2015. The DMH Division of Children and Youth staff conducted a presentation on “The Importance of Education” as it relates to the educational history of Native Americans, alcohol and drugs, self-esteem, mental illness and poverty. The speaker discussed the benefits of education for youth. Members of the Choctaw Tribe also participate in the annual Mississippi Day of Diversity initiative sponsored by the Department of Mental Health. In addition, youth from the NFusion programs in Philadelphia, Meridian, and Newton attended the 2015 Annual Youth Leadership Conference as well as staff from the DMH.

## **10. Quality Improvement Plan**

The Bureau of Quality Management, Operations and Standards is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH standards, provision of support to programmatic divisions/bureaus with the DMH to assist with information management and reporting, oversight of agency and provider emergency management/disaster response systems to ensure continuity of operations within the public mental health system, management of the serious incident reporting system for DMH certified providers, operation of DMH's information and referral services, and oversight of constituency services. In order to carry out these functions, the Bureau of Quality Management, Operations and Standards is comprised of the Division of Certification, the Office of Consumer Support and the Office of Incident Management.

The Division of Certification is responsible for provider certification across the three populations served by the DMH – mental health, intellectual/developmental disabilities, and substance use. The DMH operates on a three year certification cycle to ensure that all DMH certified providers have an on-site compliance/certification visit at a minimum of twice during that certification cycle. In addition to the on-site compliance visits, the DMH regularly conducts visits to certified providers to certify additional new programs and services. The DMH does institute a CQI process as part of its monitoring. As issues of noncompliance are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues and maintain ongoing compliance. Providers develop plans of compliance to the DMH for approval and subsequent implementation. In turn, the DMH conducts follow up visits to ensure that corrective action is taken and remains ongoing. The DMH tracks all deficiencies to identify trends and patterns and make changes to policy as needed.

The Office of Incident Management is responsible for both DMH's disaster response and preparedness activities and managing the serious incident reporting system utilized by the DMH certified providers. In responding to statewide emergencies, the DMH's Director of the Office of Incident Management serves as the liaison between the Department and the MS Emergency Management Agency. In the State's Comprehensive Emergency Management Plan, the DMH serves as a support agency for ESF 6, ESF 8 and ESF 15. The DMH maintains a statewide emergency response plan and continuity of operations plan. The DMH requires all certified providers to maintain both disaster/emergency response plans and continuity of operations plans specific to their local sites and emergency management/disaster response structures at the local level.

The DMH tracks and responds to serious or critical incidents. The DMH defined serious incidents which include categories such as: suspected abuse, neglect or exploitation, injury occurring at a program location, death, suicide attempt at a program location, elopement from a program, medication errors, etc. Certified providers are responsible for reporting serious incidents to the Office of Incident Management within 24 hours. The Office of Incident Management triages all reports, assigns a category of incident, and level for DMH response/follow-up. The Office of Incident Management conducts on-site follow up on serious incidents assigned a Level III. The Office of Incident Management also utilizes a CQI approach to its follow up process. As issues are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues. Providers develop and implement corrective action to prevent future occurrence.

The Office of Consumer Support is responsible for operating the state's grievance system. Individuals may report a grievance regarding the care of someone receiving services through the public mental health system. All certified programs are responsible for posting DMH's 1-877 line

in the program areas and incorporating the Office of Consumer Support into their local level grievance procedures that are shared with all people receiving services. Much like the serious incident management system, the Office of Consumer Support triages all grievances received, assigns a category of grievance and a level for DMH response/follow-up. The DMH's target for resolution of grievances is 30 days from the date filed.

## **11. Trauma**

As required by the Department of Mental Health's Operational Standards, Mental Health Providers certified by the Department of Mental Health has integrated trauma screening practices into the initial intake assessment process for individuals receiving services. All new cases must have a Trauma screening with documentation in the individuals receiving services chart.

Since 2006, providers of children and youth mental health services in Mississippi are being trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT). To date, there are 351 TF-CBT Therapists, 95 SPARCS Therapists and 15 CPC-TFC Therapists.

Mississippi also has (3) three National Child Traumatic Stress Network Sites. They are Catholic Charities, Inc., Region 13/Gulf Coast Mental Health Center, and Wilson-Sigrest, LLC. In direct response to the needs from Hurricane Katrina, Mississippi was the 1st State to have a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) state level Learning Collaborative coming out of National Child Traumatic Stress Network (NCTSN). In 2012 and 2013, the Department of Mental Health received Technical Assistance from SAMHSA's National Center of Trauma Informed Care. This included speakers for regional trainings and on-site visit to Mississippi State Hospital.

The Department of Mental Health, Division of Children and Youth Services continue to provide trauma-informed trainings to community and state partners including family members and caregivers. There have been over 30 learning sessions held, comprising a mix of small workgroups (e.g., 11 participants) and large workshops (e.g., 600 participants) to over 3500 participants connected to the MS System of Care. These also include keynote and breakout sessions at state conferences (e.g., System of Care, Corrections, Child Welfare, Juvenile Justice, Addiction, and Drug Court Education.)

Information obtained from 1,026 evaluation forms completed by participants at the conclusion of the learning sessions held indicated an increased knowledge of the four learning objectives. This number does not reflect the total number of participant as several did not complete evaluations due to various reasons including leaving before the end of the training or failing to return evaluation forms prior to leaving training. Participants were asked to compare their knowledge from Not Very Well to Very Well at the end of the training. **95%** of participants reported the training met their professional, personal and/or educational needs. **89%** of participants reported they could immediately apply the information in their practice, service setting and/or personal relationships.

In 2013, the Department of Mental Health, NFusion X (SOC site) and East MS State Hospital/Bradley Sanders Adolescent Complex (Psychiatric Hospital) participated in a one year Trauma Learning Collaborative with the National Council for Behavioral Healthcare. The collaborative consisted of webinars, consultation conference calls and face-to-face meetings.

The 6 Domains and Performance Standards addressed in the learning collaborate include:

- Early Screening and Comprehensive Assessment of Trauma
- Consumer Driven Care and Services

- Trauma Informed, Educated and Responsive Workforce
- Trauma Informed, Evidence-Based and Emerging Practices
- Create Safe and Secure Environment
- Engage in Community Outreach and Partnership Building

Highlights of the Learning Collaborative included:

- Implementation of the North Shore – Long Island Jewish History Checklist
- Staff Education and Training to over 150 East MS Staff
- Partnership with local system of care grantee to improve community outreach
- “Violence, Trauma and Healing: The Impact of Children and Families” workshop on 5/31/2014
- Revisiting policies for Alternative to Restraints and Seclusions, PRN Medications, and Staff Incidents involving patients
- 4 staff members completed in TF-CBT Learning Collaborates
- Blueprint for other psychiatric hospitals

In 2014, the Department of Mental Health held its first state-wide Trauma Conference. The “Trauma: The Silent Storm That Impacts Us ALL” Conference was held Tuesday, September 9th through Thursday, September 11, 2014 at the Jackson Convention Complex. The conference consisted of 5 Pre-Conference sessions, 28 breakout sessions, 6 plenary sessions and 1 Post Conference session. There were over 600 participants representing mental health and substance use professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more.

Highlights of the conference included keynote presentations by:

- Kevin Hines, Author and Professional Speaker, who is one of 33 individuals who survived after jumping off the Golden Gate Bridge, and the only survivor who shares his story of recovery and hope. Accompanying Kevin Hines was Kevin Briggs. He retired from the California Highway Patrol after 23 years patrolling the Golden Gate Bridge. He shared strategies of how he successfully prevented more than 200 individuals from completing suicide but also retiring after he could not separate his job from his personal life.
- Coach Alfred Powell received a standing ovation following his innovative presentation, “My Trauma is My Drama.” The presentation included the correlation between trauma, violence and undiagnosed mental health issues in the African American community.
- Mississippi’s own experts, Dr. Kim Shackelford and Kelly Wilson also received rave reviews. Dr. Shackelford provided practical examples of preventing Secondary Traumatic Stress and the importance of self-care. Kelly Wilson closed the conference discussing the 12 core components of trauma referencing events in her life as examples of the core components.

The 2015 Trauma Conference is scheduled for September 16 -18<sup>th</sup> and will also include a Pre-Conference on September 15, 2015 for First Responders.

The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families in 2011. The campaign, Operation Resiliency, reaches all National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. The Department

of Mental Health provided materials to more than 12,000 Mississippi National Guard during Suicide Prevention Month – September 2011 – and continues to provide educational materials. In 2012, the campaign was expanded to VA Centers across the state. Campaign materials include a resource guide - which highlights what services are available in different parts of the state, brochure and poster with tear off cards. The materials focus on: what stress can lead to, dispelling stigma in order to increase help seeking behaviors, warning signs, how to handle stress, and knowledge about available resources. The posters were placed in restrooms at all Mississippi National Guard Units so people could tear off a “get help” card in private.

## **12. Criminal and Juvenile Justice**

The MAYSI-2 is utilized by the youth courts and detention centers across the State of Mississippi in identifying youth, 12-17 years, who may have special mental health needs. It is administered upon intake for probation or detention. If the score alerts the youth intake worker for a more in-depth assessment, a referral is made to the local Community Mental Health Center. Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need.

The Department of Mental Health, Division of Children and Youth Services collaborates with the Division of Youth Services, Department of Human Services to implement Adolescent Opportunity Programs (AOP) in eight (8) Community Mental Health Centers across the state. AOPs are community-based partnerships that share resources and services to reduce the number of at-risk youth being placed in state custody. AOPs target adjudicated delinquent youth ages 12-17 years who are at high risk of becoming further involved in the criminal justice system. The program operates on a 12 month basis, until the youth completes all three phases of the program or completes his or her probation sentence. Services provided through the program include day treatment, group/individual/family therapy, recreational therapy, parent/caregiver education, and life skills coaching. The DMH, Division of Children and Youth Services staff actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide.

## **15. Crisis Services**

The MS DMH provides approximately \$4,750,000 to the 14 CMHC’s in MS to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC’s regions. The calls received by the crisis phone line are triaged for severity. Some calls can be handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team. Each CMHC region is required to provide mobile response services in every county they serve. The mobile crisis response teams must be able to respond with one hour in an urban area and within two hours in a rural area. The mobile crisis response teams are required to have a Master’s level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity. Additionally, if the mobile crisis response team must respond in an area that may not be safe, the will have law enforcement accompany them. A strong working relationship with law enforcement is required through the grant funding. The mobile crisis response team will triage during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with

psychiatric care available. The mobile crisis response team is also required to develop working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The mobile crisis response team is also tasked to follow-up within 24 hours of a face-to-face contact with an appointment at the CMHC. The “warm-handoff” model is used to facilitate services for the person in crisis with the next provider. Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter “regular” services with the CMHC or other provider. All individuals receiving services at a CMHC who has recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMHC staff and any significant others the individual wants involved. The individual is able to design a plan for how they want to be treated the next time they are in crisis which the CMHC staff and others, such as law enforcement, chancery court, etc... can follow in the event of a subsequent crisis. As part of the crisis response system, the CMHC’s are required to develop a multi-disciplinary assessment and planning team (Map Team) made up of all the agencies that work with the most well-known individuals in the community. The Map Teams usually consists of mental health, health, human services, police department, sheriff’s office, chancery clerk, faith based ministries, housing, etc... to develop a plan for the individuals in their community which consume the most time from all these agencies. The Map Teams are encouraged to find an alternative to continually committing the same individuals over and over to one of the State behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff’s Office to develop Crisis Intervention Teams (CIT)) across the state. The Lauderdale Sheriff’s Office is a training site for officers from anywhere in the state to come the 40-hour training required to be a CIT officer. The local CMHC is fully involved in the curriculum development and presentation. The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions.

DMH would like technical assistance with Wellness Recovery Action Plan (WRAP) crisis planning, Peer-operated warm lines, peer-run crisis respite programs, and the Living Room Model.

## **16. Recovery**

The Mississippi Department of Mental Health has adopted the philosophy that “all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented” as highlighted in the Mississippi Board of Mental Health and Mississippi Department of Mental Health Strategic Plan. The FY16 – FY18 DMH Strategic Plan includes objectives focused on utilizing peers and family members to provide varying supports to assist individuals in regaining control of their lives and their recovery progress. These objectives are met through the Certified Peer Support Specialist Program, recovery-oriented system of care trainings, Personal Outcome Measures (POM), and other activities. The Plan also includes strategies to increase the use of Wellness Recovery Action Plans (WRAP) and Whole Health Action Management (WHAM) at DMH’s behavioral health programs. In 2014, DMH established a Division of Recovery and Resiliency within the Bureau of Outreach, Planning and Development. The Division administers the Certified Peer Support Specialist Program for people who have lived experience of mental illness and/or substance use disorder and/or family members who want to provide peer recovery services to others. The Division is responsible for implementing the Think Recovery awareness campaign and moving the public mental health system towards a recovery-oriented system of care.

## **Involvement of Individuals and Families**

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. Efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health system include:

**Planning Services** – Consumers and family members have an opportunity for meaningful participation on planning councils, task forces and work groups on a state, local, and national level.

**Delivery of Services** – Consumers and family members are employed as certified peer support specialist and/or peer support specialist.

**Evaluation of Services** – Consumers and family members have an opportunity to participate on personal outcome measure interviews using the Council on Quality of Life Personal Outcome Measures. The personal outcome measure interviews provide an opportunity for consumers and family members, through a guided conversation, to evaluate quality of life. Consumers and Family members, on a local level are involved in consumer and family satisfaction surveys.

The DMH sponsors meetings with peer support specialists and certified peer support specialists to discuss the role of peer support and barriers to provision of peer support services within the behavioral health service system. The DMH also sponsors Mental Health Planning Councils and various task forces, work groups and committees as an avenue to address issues and needs regarding the behavioral health service system.

Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning; shared decision making; and direct their ongoing care through the Breakthrough Series. The DMH provides trainings to peer specialists and is working with advocacy groups, consumers and family members to develop a system that affords consumers and family members the opportunity for meaningful participation in treatment, service delivery system, etc.

Based on the 2014 Advisory Council Survey, individuals and family members are in leadership positions within our state planning councils. Specifically, the Chairperson of two of the state's four Planning Councils is either a family member or individual receiving services. As a result of the survey, DMH hosted a Leadership Academy in May to offer individualized training for 25 people to focus on how to expand their current role and serve on taskforces, workgroups, etc.

## **Housing**

Included in the DMH Strategic Plan are several objectives and strategies for improving and expanding housing opportunities that will enable more individuals to be served effectively in fully integrated community living. During calendar year 2012, a significant DMH Strategic Plan benchmark was achieved with the establishment of a DMH Division of Housing and Community Living and appointed a full-time director of this new Division. In order to be successful in addressing housing needs of persons served, additional Strategic Plan objectives include increasing the percentage of funding allocation to housing as a priority service as well as seeking to provide a full array of supported housing services in communities throughout the state. In the FY16 – FY18 DMH Strategic Plan, the agency will focus on increasing the availability of community

supports/services for people with SMI in order to implement the Permanent Supportive Housing model.

The DMH realizes that in order for individuals served to live successfully in the community, a full array of supportive services needs to be developed and maintained. This is also addressed in the DMH Strategic Plan with an objective to provide community supports for persons transitioning to the community through participation in the Mississippi Division of Medicaid's Money Follows the Person (MFP) demonstration project. Within the scope of the MFP project, the DMH is actively implementing a plan to expand Medicaid-funded Waiver Services to enable individuals with IDD to transition from DMH residential programs to fully integrated community living. In conjunction with the expansion of Waiver Services, there is specific funding in MFP for specific, time-limited costs associated with helping individuals successfully transition to the community of their choice.

Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program and to work with the transition team at each program.

### **Certified Peer Support Specialist Program**

The DMH's Peer Support Specialist Program began in 2012. Since then, a total of 165 people have been trained and 118 are Certified Peer Support Specialists (CPSS). CPSSs are required to have 20 hours of continuing education. A CPSS is a family member and/or individual who has self-identified as having received or is presently receiving behavioral health services. Additionally, a CPSS has successfully completed formal training recognized by the DMH and is employed by a DMH Certified Provider. These individuals use their lived experience in combination with skills training to support peers and/or family members with similar experiences. CPSSs support their peers both individually and in groups. Under general supervision, a CPSS performs a wide range of tasks to assist individuals to regain control of their lives and their own recovery and resiliency journey. CPSSs provide varying supports, some of which might be offered by others in the behavioral health system, but CPSSs contribute something unique. They are living proof that recovery is possible. CPSSs share lived experiences and are willing to share their stories to benefit others.

The DMH is also focused on a training program for family and parents of children with behavioral disorders defined as a Serious Emotional Disturbance (SED). Currently, there are six (6) CPSSs that identify as a parent or caregiver of a youth with SED. However, DMH and those CPSSs realize that a more specified training is needed for those family and parents who wish to work with families that are experiencing mental health challenges with their children. The DMH is working to develop a curriculum focusing on training for a Certified Parent/Caregiver Support Specialist.

The DMH contracts with eight CPSSs and one CPSS Supervisor, who serve as CPSS Ambassadors, to provide technical assistance to providers, to provide support to other CPSSs, and to conduct trainings across the state. DMH worked with the Ambassadors to create two toolkits – a CPSS Provider Toolkit (for providers interested in employing a CPSS or who want to learn more about how to utilize a CPSS) and a CPSS Toolkit (for individuals who are interested in becoming a CPSS). In collaboration with CPSS Ambassadors, DMH developed a PowerPoint based on the CPSS Provider Toolkit. The training targets the following: 1) Organizations who already employ CPSSs; 2) Organizations who have decided to employ CPSSs and would like to know how to introduce them successfully into the workplace; 3) Organizations thinking about employing CPSSs.

The DMH has monthly calls with CPSSs and Peer Support Specialists to look at employment opportunities, training opportunities, and other valuable information.

### **Personal Stories of Recovery**

The DMH saw the need for people to share their own personal stories of recovery to help inspire both providers and other individuals on their road to recovery. DMH has filmed more than 25 videos of people sharing their stories. DMH also filmed two CPSSs talking about the benefits of employing CPSSs and two CPSS supervisors sharing the difference CPSSs have made in their organizations. All videos are on DMH's Web site and one video each highlighted monthly via e-mail. The DMH also partners with NAMI-MS to host a Share Your Story Workshop twice a year to provide tips on how to effectively tell your recovery story.

### **Drop-In Center**

The Mental Health Association of South Mississippi Opal Smith Drop-In Center offers a day program for adults with mental illness and people with disabilities. Instead of being alone, people fill their day with arts, crafts and games, making friends, and gaining confidence. At the Center, they can explore personal interests in a safe, non-judgmental way and learn to become more independent in a recovery-oriented environment. The Center also develops Wellness Recovery Action Plan (WRAP) with people who come to the Center.

### **Supported Employment**

The DMH has developed and made available supported employment services based on the Substance Use and Mental Health Services Administration's Evidence-Based Practice for Supported Employment and Dartmouth Individual Placement and Supports Model (IPS). In 2015, DMH began implementation of this program with four pilot program sites operated through the Community Mental Health Centers in Region 2, Region 7, Region 10 and Region 12. These services are available for adults living with mental illness, and DMH will be collaborating with the Mississippi Department of Rehabilitation Services to leverage each agency's ability to provide employment supports.

### **Internal Training and Outreach**

The DMH distributed an internal survey to Central Office staff to gauge their understanding of recovery. As a result of the survey, DMH employees at all levels within the agency participated in a mandatory training to provide a better understanding of the ongoing transition to a recovery-oriented system of care. DMH's newly established Division of Recovery and Resiliency led the training sessions, but they did so with the help of the CPSS Ambassadors. CPSSs shared how they have been directly impacted by their own or their loved ones' struggle with mental illness. They walked DMH staff through each of the Components of Recovery. DMH staff marveled at their presentation skills and their courage to share personal information in order to help all employees understand the need and value in continuing to move toward a recovery-oriented system of care.

## **17. Community Living and the Implementation of Olmstead**

States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

### **A Statewide Approach for Integrated Supportive Housing in Mississippi**

In June 2013, the Department of Mental Health facilitated a SAMHSA-sponsored Olmstead Policy Academy to help Mississippi develop action plans to increase community integration for people with behavioral health issues. With the help of a lead facilitator assigned to us by SAMHSA, a Mississippi team spent several months developing a one-year action plan with goals and strategies

to help us promote community integration through improved housing, employment, and recovery support opportunities for people with behavioral health disorders in Mississippi. The team was made up of approximately 30 individuals representing service providers, policy makers, and stakeholders in the targeted areas of housing, employment, and recovery support. The *Olmstead* Policy Academy Strategic Plan that resulted from the efforts of the Policy Academy members identified goals, strategies, and activities for each of the three critical areas included in the plan that ultimately led to the development in 2014 of a more comprehensive, targeted state plan for statewide systematic approach to addressing the requirements of *Olmstead* and Title II of the ADA.

Multiple agencies, including development authorities, housing corporations, regional housing authorities, state departments, federally funded contractors and local contracted providers have a role in providing housing and supportive services for individuals with disabilities and life challenges in the State of Mississippi. In 2014, the State of Mississippi, through an appropriation to the Mississippi Department of Mental Health (MDMH), engaged in the development a statewide integrated, supportive housing (ISH) strategy for people with mental illness, intellectual and developmental disabilities (IDD), addictive disease, Veterans and other high need populations in Mississippi served by agencies such as the Department of Human Services (DHS), Department of Health (DOH), and the Department of Corrections (DOC). ISH refers to safe, secure and affordable housing, where tenancy is not time-limited as long as the resident pays the rent and honors the conditions of the lease. Individualized and flexible support services are available to residents based upon their choices and needs.

As part of this process, a strategic planning committee was convened to discuss and identify the challenges and barriers to the availability of supportive housing, and to make recommendations for an organized, statewide supportive housing strategy. Membership of the planning committee consisted of leadership from key state agencies that work with Mississippians who may be in need of supportive housing. Available sources of information pertaining to federal, state and local resources and affordable housing policy in Mississippi was also reviewed, as well as approaches that other states have taken to organize management of supportive housing resources for people with disabilities and other target populations. Key stakeholders and other informants were interviewed about possible housing strategies, including staff from state agencies, service providers, housing developers, public housing authorities, and service recipients. These efforts revealed that: 1) that the State of Mississippi has human service agencies (MDMH, DHS, DOH, DOC, etc.) with the expertise to provide services to individuals with disabilities and life challenges, however, these agencies do not have the expertise to create and provide affordable housing stock to scale; and 2) Mississippi needs a single designated agency to coordinate housing efforts statewide.

Three key issues were identified that Mississippi should address to improve its ability to meet the integrated, supportive housing needs of people with disabilities or other priority populations:

1. The lack of a coordinated integrated, supportive housing strategy across State agencies is resulting in missed opportunities to increase affordable housing;
2. There are limited housing resources currently available to meet the affordable housing needs of the State's low income disabled population and other priority populations; and
3. An assessment is needed of the types of services that should be provided to ensure the success of individuals who gain access to integrated supportive housing opportunities.

With limited affordable housing options, many individuals with disabilities and life challenges have had little choice but to live in the limited housing options they could afford, often in less than desirable settings, in un-safe neighborhoods or in more restrictive settings. Others with involved

families have had to return to live with them, in some cases losing the instrumental activities of daily living (IADLs) skills they may have acquired while in more independent living and in other cases affirming their families' angst over what would become of them when the families are no longer able to provide them a place to live. The recommendations below were informed by numerous interviews with stakeholders representing the continuum of housing and service agencies. There were consistent messages about the strengths and shortcomings of the current system that need to be addressed and can be built upon to create recommendations for integrated, supportive housing opportunities.

- 1) Designate the Mississippi Home Corporation (MHC) as the lead agency for the statewide housing strategy. As Mississippi's designated Housing Finance Agency, MHC is the only agency in Mississippi where housing is its core mission.
- 2) The Mississippi Legislature should establish an ongoing interagency housing council and define its role. The ISH Planning Committee could serve as the starting point, adding a few additional tactical members. The objective is to create a body that is responsible and accountable for housing resources and the policy needed to most effectively use those resources. The council should be charged with developing an integrated, supportive housing plan and submitting an annual progress report.
- 3) The Mississippi Legislature should develop and appropriate funds for a state-funded bridge housing subsidy program (HSP). The HSP should be designed to resemble the federal Housing Choice Voucher (HCV) program, and all participants should be required to apply for and transition to a form of federal rental assistance when possible. Individuals who could be eligible for the HSP should be specified in program requirements and should include people with disabilities or other priority populations served by human service agencies such as MDMH, DOM, DHS, DOH and DOC. The HSP should be administered by MHC in coordination with the relevant State agencies.
- 4) Create and appropriate funds for an ISH Coordinator position to be housed at the Mississippi Home Corporation. The responsibilities for administering and coordinating housing resources across multiple agencies are time-consuming and complex. Allocating these responsibilities to existing staff would result in an ineffective housing strategy.
- 5) Create and appropriate funds for Housing Support Specialists to assist individuals supported by the bridge housing subsidy program with pre-tenancy and post-tenancy activities.
- 6) Obtain specific housing needs data for targeted subpopulations and establish criteria for who is in need of integrated supportive housing. While each agency may have some data on the housing needs of individuals the agency serves, there is not a mechanism for aggregating and un-duplicating data across agencies to create a valid and reliable data set. This activity will require clearly defining the target population(s) and establishing criteria for who is in need of ISH.
- 7) Initiate immediate planning for the U.S. Department of Housing and Urban Development (HUD) FY 2015 811 Project Rental Assistance (PRA) application. PRA funds are awarded to State Housing Finance Agencies to create deeply affordable supportive housing units for people with disabilities within mainstream affordable housing (either existing or to be established) developments financed by the State

Housing Agency through programs such as the Low Income Housing Tax Credit (LIHTC) program, the HOME program, state bond financing, etc.

- 8) Identify additional housing resources with potential to adopt a disability and homeless preference in accordance with HUD guidance. For example, in July 2013, HUD issued Notice H: 2013-21 in which it clarified that private owners of HUD-assisted Section 8 project based assistance could request a homeless preference from HUD. As such, private owners and developers whose properties have Section 8 project based assistance can request a preference from HUD to serve homeless persons. The new ISH Housing Coordinator could convene meetings of owners of such Section 8 HUD-assisted housing to identify a strategy for Mississippi.
- 9) Work with Public Housing Authorities (PHAs) to establish an Olmstead preference, thereby increasing the possibility that people with disabilities who may be part of an Olmstead class are more likely to access federal rental assistance.
- 10) Evaluate the adequacy of existing services and funding for services, as well as the need for alternative approaches, to ensure the success of individuals who gain access to supportive housing.

Additional resources will be needed if Mississippi is to commit to a *sustainable pipeline* of integrated, affordable housing and services to meet the need of individuals with disabilities.

(Portions of the information Excerpt from the full report prepared by TAC: *A Statewide Approach for Integrated Supportive Housing in Mississippi, October 2014*)

During Mississippi's Legislative session that ended in April 2015, a bill was passed and signed by the Governor to fund a State Bridge Subsidy voucher targeted to individuals identified in Olmstead and included in a joint agreement letter dated August 29, 2014 between the US Department of Justice and the Attorney General of Mississippi. Implementation of the new state-funded bridge subsidy program will be administered by the MS Home Corporation (MHC) which is Mississippi's Housing Finance Agency in direct partnership with the MS Department of Mental Health (MDMH) and with active participation by the state's Community Mental Health Centers (CMHC). Each partner entity will identify a Point of Contact to be primarily responsible for managing the process for transitioning individuals from a state hospital to the community. Here are the usual steps in the transition process:

1. Hospital POC will send discharge/referral information to POC at MDMH.
2. POC at MDMH will contact POC at CMHC to initiate the process.
3. A VI-SPDAT screening to identify level and type of housing needed will be completed.
4. CMHC will contact MHC to enroll the individual in the MHC Bridge Subsidy program.
5. The State hospital POC will coordinate the individual's discharge to the community with the CMHC.
6. If MHC Bridge Subsidy is not available at the time of discharge, CMHC will develop/implement a temporary housing and services plan until a slot in the MHC Bridge Subsidy program is available.
7. CMHC and MHC will coordinate transition from temporary housing setting to a Permanent Supportive Housing setting when slot becomes available. CMHC supportive services will continue.

## **18. Children and Adolescent Behavioral Health Services**

The Mississippi Transitional Outreach Project (MTOPI), a six-year CMHI Cooperative Agreement and Project XPand, a four-year System of Care implementation initiative created the Executive Steering Committee to provide interagency state-level input and direction to the local programs

implementing the programs. In FY 13, the Bureau of Alcohol and Drug Services was awarded a State Adolescent Treatment Enhancement and Dissemination (SYT-ED) grant. State and local level project staff joined the Executive Steering Committee to incorporate plans for assessments and services to youth with SED and substance use disorders. The Executive Steering Committee meets monthly to share updates on the implementation of evidence-based practices, policy and procedures revision, programming, evaluation and data reports. Additionally, the DMH's Bureau of Alcohol and Drug Services and Division of Children & Youth Services are part of SAMHSA's Transforming, Linking and Coordinating for Youth (TLC-Y) initiative as both CMHS and CSAT grantees. States part of the TLC-Y initiative receive technical assistance on coordinating efforts between both grants serving youth/young adults including financing a continuum of effective assessment, treatment and support services for youth/young adults with SED and substance use disorders.

Guidelines for individualized care planning for children and youth with mental, substance use and co-occurring disorders have already been established through the DMH Operational Standards and the DMH Record Guide. The DMH certified providers utilize an Individualized Service Plan that includes strengths, long term and short term goals, objectives and outcomes. For those youth with co-occurring disorders, a substance use specific assessment is also utilized in addition to the initial assessment.

The Interagency Coordinating Council for Children and Youth and the Interagency System of Care Council (ISCC) have representatives of the Department of Human Services, Division of Youth Services (juvenile justice), Department of Human Services, Division of Family and Children Services (child welfare), the Attorney General's Office, Department of Education, Department of Health, Department of Rehabilitation, Division of Medicaid, Community Mental Health, family/parents, family-operated agencies, youth/young adults, a psychiatrist and representatives from the DMH to include behavioral health, substance use and intellectual/developmental disabilities. The ISCC meets quarterly to coordinate training, coordinate services, build local infrastructure, exchange data, apply for grants and also serve as the oversight governance council for all system of care projects in the state. Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Members of each local team include family members, the community mental health service providers, county human services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services.

The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work to establish the Mississippi Wraparound Initiative (MWI). MWI has four national certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. The Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) annually. Numerous DMH staff are certified trainers in Mental Health First Aid for Youth (MHFA-Y) and Applied Suicide Intervention Skills Training (ASIST), safe TALK, and Question, Refer and Persuade (QPR). DMH trainers provide trainings upon requests to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies.

The DMH collects data on service utilization through the Central Data Repository (CDR). Providers of mental health services collect and input data into the CDR on a monthly basis. Additionally, a random sample of individuals representing various age groups, ethnicities, and backgrounds participate in statewide consumer satisfaction surveys through their local CMHCs. Results of these surveys are utilized to assess the quality of services being provided in the CMHCs and assist DMH in supporting and guiding service development. The DMH Division of Children and Youth Services gains additional information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, and through the work of the State-Level Interagency Case Review Team, and a System of Care initiative, the Mississippi Transitional Outreach Program, described in more detail in the State Plan. Furthermore, The DMH management staff receives regular reports from the Division of Office of Consumer Support (OCS), which tracks requests for services by major category, as well as receives and attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system. Finally, through an ongoing certification and review process, the DMH ensures implementation of services which meet the established operational standards.

The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges. School-based therapists employed by the CMHCs 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. Interagency agreements between schools and CMHCs providing school-based Services are verified on monitoring visits by DMH staff.

In Mississippi, Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the current DSM and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. The Division of Children and Youth Services, the Division of Adult Community Services and the Bureau of Alcohol and Drug Services have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. The Transitional Services Task Force was formed to better identify and plan to assess needs of youth, age 16 to 25 years. This task force, now called the Executive Steering Committee, has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Committee includes representatives from a local mental health center, the Division of Medicaid, the Office of the Attorney General and the DMH Bureau of Community Services. The work of this committee and its members assisted in the development of successful grant applications for a Children's Mental Health Initiative targeting transition – aged youth. This six-year System of Care grant is providing funds for the implementation of three Transitional Outreach Programs (MTO) across the state and most recently, a four-year grant that expands MTO to two additional counties. In addition, the DMH Division of Children and Youth Services also provides funding for providers of transitional living services programs that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. The DMH provides funding to four of the six DMH certified transitional therapeutic group homes.

## **21. Support of State Partners**

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

In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care. Representatives from various State agencies participate on the Mississippi State Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. Letters of Support from the Division of Medicaid, the Mississippi Department of Human Services, the Mississippi Department of Health, the Mississippi Department of Rehabilitation Services, the Lauderdale Sheriff's Department, the Mississippi Department of Human Services/Division of Youth, the Mississippi Department of Public Safety, the MS Band of Choctaws, Mississippi Department of Education, and MEMA will be submitted with the state plan application.

*These state agency partners provided the following information:*

### **Division of Medicaid, Office of the Governor**

#### **(Adults)**

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

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

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

The Department of Mental Health worked with the Division of Medicaid to develop a proposed State Plan Amendment submission to the Centers for Medicare and Medicaid Services (CMS) for MYPAC to sustain as a mental health rehabilitative service. CMS approved MYPAC as a state plan rehabilitative service on January 1, 2013, which continues to facilitate changes in community

mental health services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Office of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults.

In February 2011, the Mississippi Division of Medicaid was one of 13 states awarded the Money Follows the Person demonstration grant. The state will receive \$37 million over the next six years. The Department of Mental Health has worked closely with the Division of Medicaid to assist in this effort. It is anticipated that demonstration will increase the ratio of community-based service spending compared to institutional spending over the course of the six-year grant. Cost savings achieved by transitioning people out of institutions will be directed into community-based services. This will help to eliminate barriers that prevent or restrict flexible use of Medicaid funds and enable individuals to receive long-term care in the setting of their choice. The goal of the demonstration project is to help 595 persons with disabilities or the elderly transition out of institutions by 2017.

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

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

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

effective treatment and management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age.

Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, the DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. The 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 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 use, in addition to medical care. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

Health/Medical/Dental Services are addressed by community mental health centers with other support services to adults with serious mental illness as part of local CSP plans, which are required as part of local providers' applications for CMHS block grant funds. CMHCs provide medical and dental services in a variety of ways, with the primary avenues being: 1) use of community health centers; 2) use of State Department of Health county health offices/services; 3) pro bono work by physicians and dentists; 4) University Medical Center services; 5) contributions by mental health associations and other local nonprofit/charitable organizations; 6) emergency medical/dental funds maintained by the provider program, including DMH funding for purchase of psychotropic medications; and 7) contributions by individuals and businesses. Of course, some medical and dental services are paid through the Medicaid and Medicare programs.

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## **Division of Medicaid (Children)**

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by MSDH for psychiatric services for adults in FY 2011. The Department of Health also collects data on private chemical dependency treatment facilities it licenses and reported 52 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adolescents and 279 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

The University of Mississippi Medical Center (UMMC), Department of Psychiatry and Human Behavior has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for senior psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Clinical psychology residents and faculty are collaborating with Harbor House (nonprofit community treatment program for adults with substance use problems); psychology residents and child psychiatry residents also have clinical rotations at Mississippi Children's Home Society/CARES, a nonprofit program serving youth. Additionally, two UMMC child psychiatrists and fellows provide services at the Oakley Training School, and plans are under development regarding provision of psychiatric services via telehealth by UMMC clinical staff to a facility operated through the Mississippi Department of Corrections.

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

Social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The DHS Division of Family and Children's Services provides child protective services, child abuse/neglect prevention, family preservation/reunification, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The DHS Division of Family and Children's Services and the Division of Youth Services work closely with the Department of Mental Health through participation on the Mississippi State Mental Health Planning Council, MAP teams, and other committees. The DHS Division of Field Operations provides Temporary Assistance for Needy Families (TANF), TANF Work Program (TWP), child support enforcement and location, Supplemental Nutrition Assistance Program (SNAP), the Disaster Supplemental Nutrition Assistance Program (DSNAP), the Emergency Food Assistance Program (TEFAP), and SNAP Nutrition Education (SNAP-Ed). The DHS Division of Youth Services provides counseling, delinquency probation supervision, and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, and oversees the state training schools. The DHS Division of Family Foundation and Support provides child support legal and collection services, Healthy Marriage, Teen Pregnancy, and Fatherhood initiatives as well as the Access and Visitation Program for non-custodial parent visitation. The DHS Division of Children and Youth provides certificates for child care services for TANF clients, child welfare clients, and some working foster parents. The DHS Division of Aging and Adult Services (DAAS) plans, advocates for, and coordinates the delivery of services to adults 60 years of age and older through a system of local Area Agencies on Aging (AAAs). The DAAS's goal is to provide support services to help people remain in their own homes and local communities. The DAAS

developed a single point of entry system for the aged and adult population with disabilities: the Aging and Disability Resource Center, called Mississippi Get Help. The project was piloted in central Mississippi and continues to expand services statewide with a toll-free, telephonic, virtual web-based, and face-to-face resource center that provides access to information, as well as assistance in applying for services. The “no wrong door” approach assures the public consistent information and assistance. In addition, it helps the public navigate through what can seem like a maze of government assistance, as well as the private and nonprofit service system. The Division of Aging and Adult Services also investigates abuse, neglect, and exploitation of vulnerable adults, ages 18 and older in private settings, under the Adult Protective Services program. The DHS Division of Community Services provides services such as homeless resource referrals and low income utility assistance. Additional social services and financial assistance are accessed as needed for adults with serious mental illness and are administered through various public service agencies/organizations, such as the MS Department of Human Services (described above), the Division of Medicaid, the Department of Health, the Social Security Administration, the Cooperative Extension Service, the Salvation Army, churches, etc. Examples of this assistance include SNAP benefits, medical/other financial assistance, nutrition services, protective services, transportation, financial counseling, etc.

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## **Justice Services**

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) 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. Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers. The officers receive approved continuing education credits from DPS.

Lauderdale County has established the Lauderdale County Community Partnership (LCCP) to develop a Crisis Intervention Team (CIT) program in Meridian. The partnership includes members from Lauderdale County Sheriff’s Department, Meridian Police Department, Weems Community Mental Health Center, Alliance Health Center, Rush Hospital, Riley Hospital, Anderson Regional Medical Center, NAMI, Central Mississippi Residential Center, and the DMH. The single point of entry for the CIT program is the Newton CSU. To date, LCCP has conducted seven 40 hour training classes and graduated 85 CIT officers. Another class is scheduled for August 2015 with an expected 15 officers attending.

The DMH has entered into a contract with Lauderdale County Sheriff’s Department to allow officers from around the state to attend CIT training in Meridian at no cost to the other law enforcement agencies. The DMH has mailed letters, brochures and a video promoting the CIT training opportunity to all 82 sheriff’s departments and to 49 of the major police department around the state.

Governor Phil Bryant declared February 2015 CIT Awareness month.

The DMH has partnered with DPS to recognize officers who have completed CIT training. Officers completing CIT training receive a certificate from the DMH and DPS signed by Ms. Diana Mikula and Commissioner Santa Cruz and they get 40 hours of CE from DPS.

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## **Protection and Advocacy: Disability Rights Mississippi**

Disability Rights Mississippi (DRMS) is a private, nonprofit corporation established to protect and advocate for the rights of individuals with disabilities in Mississippi. Disability Rights Mississippi is independent of any agency, organization, or governmental unit providing treatment, services, or habilitation to individuals with disabilities. The agency provides information, referral, outreach, training, short term assistance, and legal advocacy. A Board of Directors governs the agency. The purpose of Protection and Advocacy for Individuals with Mental Illness (PAIMI) program within Disability Rights Mississippi is to protect and advocate for the rights of persons with mental illness. The PAIMI program has an active Advisory Committee (PAC) and the majority of its members are individuals diagnosed with mental illness or family members of such individuals. Services provided through the PAIMI program include information and referral; technical assistance; advice and support for persons who plan to advocate for themselves, their rights and needed services; assistance in meetings and negotiations; representation in administrative appeals and hearings; and litigation, usually in cases where the outcome could benefit many individuals. Additional services designed to enhance the rights of all persons labeled mentally ill include: public information and education regarding the needs and rights of persons labeled mentally ill; monitoring of state institutions and private and public psychiatric hospitals; investigations of allegations of serious abuse or neglect; identification of problems in the systems of service delivery; and advocacy to improve the service delivery system. DRMS provides advocacy and legal assistance to persons with mental illness living in a variety of settings, including jails, personal care homes, detention facilities, group homes, nursing homes, and those living independently.

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## **Families As Allies**

The Division of Children and Youth continues to provide financial support to Families as Allies, the only family-run statewide organization for parents and caregivers of children with mental health challenges in Mississippi. Families as Allies is the State Chapter of the National Federation of Families for Children's Mental Health and the recipient of SAMHSA's Statewide Family Network grant. Families as Allies' Mission is to make sure families are partners in their children's care and its core values are valuing every child and family, partnership, excellence and accountability. Families as Allies provides a wide array of family-to-family support, education and advocacy opportunities and works at the policy level to challenge all of the child-serving systems to reflect the same core values in their work.

CMHS block grant monies fund Family Partners who provide support and referral services to families who call from throughout the state. These same Family Partners attend meetings with families, assist them in writing letters and filing relevant complaints, facilitate group activities and teach advocacy skills. Respite care by specially trained workers is provided at all group family activities and also funded through block grant funds. Families as Allies responds to about 150 calls per month and staff attends about 60 family meetings, 15 – 20 policy meetings and conduct five – six community outreach activities during the same time period. Over the past year, a number of board development activities have been conducted and documentation of program, personnel and financial data has become more systematic in preparation for electronic record keeping. Increased use of social media and Constant Contact has allowed broader and more comprehensive feedback from families to determine unmet needs, including participation in a comprehensive assessment of the Children's SOC completed by the Technical Assistance Collaborative.

Under the Statewide Family network grant, Family Partners provide technical assistance to families to find support and create system change in different regions while still developing a comprehensive statewide family network. This work has led to Families as Allies developing a Leadership Training curriculum that has been conducted with families five times over the past year. It also serves as the foundation for a comprehensive curriculum for Parent Support Providers that is

consistent with the national core competencies and certification exam. Families as Allies is working on the curriculum in partnership with other state family organizations, FREDLA and the Federation and anticipates it being complete within the next year. Families as Allies also provides the MAP Teams with technical assistance on SOC principles, especially to help family-driven care, and hopes to do the same with the other statutorily mandated SOC committees when they are meeting more regularly.

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### **Educational Services: Mississippi State Department of Education**

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

In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning. Section 504 Teacher Units are also approved through the Department of Education to local school districts for community residential programs for adolescents with substance use problems and other areas under Section 504 criteria. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. Children with serious emotional disturbance who meet eligibility criteria for a disability in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. A free appropriate public education (FAPE) must be available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP). After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment. Those services could include a functional behavioral assessment, behavioral intervention plan, and other positive behavioral interventions and supports determined by the IEP Committee. Each district must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities who reside within their jurisdiction for the provision of special education and related services. It is the IEP Committee, which includes the parents, that determines the appropriate special education and related services (including transition services) and placement of a student with a disability. Any related service required by a student necessary to benefit from their special education services and any transition services determined appropriate by the IEP Committee must be provided at no cost to the parent. These related services include, but are not limited to: Audiology, Counseling, Early Identification and Assessment of Disabilities in Children, Interpreting Services, Medical Services, Occupational Therapy, Orientation and Mobility Services, Parent Counseling and Training, Physical Therapy, Psychological Services, Recreation,

Rehabilitation Counseling Services, School Health Services and School Nurse Services, Social Work Services, Speech-Language Pathology, and Transportation. All districts in the State must provide all services as determined by the IEP Committee in accordance with the IEP.

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

### **Students Ruled EmD under the Individuals with Disabilities Education Act of (2004)**

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

### **Other Educational Services and Initiatives**

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

The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling. Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses counseling, psychological services and the needs assessment. One of the eight components of the Center for Disease Control and Prevention's (CDC) coordinated school health is counseling and psychological services. In accordance with this component, Mississippi public schools are required to establish a local school wellness policy.

### **Mississippi State Department of Health and Division of Medicaid**

Health/Medical/Dental Services are accessed through case management for children of all ages with serious emotional disturbance. These services are provided through a variety of community

resources, such as through community health centers/clinics, county health department offices, university programs and services and private practitioners.

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

The MS Department of Health (DOH) also makes available certain Child Health Services statewide to children living at or below 185 percent of the non-farm poverty level and to other children with poor access to healthcare. The Child Health services include childhood immunizations, well-child assessments, limited sick child care, and tracking of infants and other high risk children. Through other internal programs and community initiatives, the Department of Health works to address issues such as teen pregnancy, tobacco use, unintentional injuries, and promotes specific interventions to decrease infant mortality and morbidity. Services are preventive in nature and designed for early identification of disabling conditions. Children in need of further care are linked with other State Department of Health programs and/or private care providers necessary for effective treatment and management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age. Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, the DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. The 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 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 use, in addition to medical care. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

Health/Medical/Dental Services are addressed by community mental health centers with other support services to adults with serious mental illness as part of local CSP plans, which are required as part of local providers' applications for CMHS block grant funds. CMHCs provide medical and dental services in a variety of ways, with the primary avenues being: 1) use of community health

centers; 2) use of State Department of Health county health offices/services; 3) pro bono work by physicians and dentists; 4) University Medical Center services; 5) contributions by mental health associations and other local nonprofit/charitable organizations; 6) emergency medical/dental funds maintained by the provider program, including DMH funding for purchase of psychotropic medications; and 7) contributions by individuals and businesses. Of course, some medical and dental services are paid through the Medicaid and Medicare programs.

The MS Department of Health (MSDH) also makes available certain specialized health care programs. Through other internal programs and community initiatives, MSDH works to address issues such as teen pregnancy, tobacco use, and unintentional injuries, and to promote specific interventions to decrease infant mortality.

Outpatient mental health services are also available through licensed practitioners in the private sector, whose scope of practice and services are regulated by their respective licensure boards/agencies and payors of their services (insurance programs, Medicaid, etc.). The Department of Health, which collects data on psychiatric facilities it licenses, reported 270 licensed and/or CON approved inpatient beds for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units) and 535 licensed/inpatient beds, with an additional two beds held in abeyance and 24 CON approved beds by MSDH for psychiatric services for adults in FY 2011. The Department of Health also collects data on private chemical dependency treatment facilities it licenses and reported 52 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adolescents and 279 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

The University of Mississippi Medical Center (UMMC), Department of Psychiatry and Human Behavior has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for senior psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Clinical psychology residents and faculty are collaborating with Harbor House (nonprofit community treatment program for adults with substance use problems); psychology residents and child psychiatry residents also have clinical rotations at Mississippi Children's Home Society/CARES, a nonprofit program serving youth. Additionally, two UMMC child psychiatrists and fellows provide services at the Oakley Training School, and plans are under development regarding provision of psychiatric services via telehealth by UMMC clinical staff to a facility operated through the Mississippi Department of Corrections.

## **22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health Block Grant Application**

The Mississippi State Mental Health Planning and Advisory Council participated in the development of the FY 2016-2017 Mississippi State Plan for Community Mental Health Services. Council members serve as advocates for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses through promotion and assistance in planning and developing comprehensive mental health treatment, support, and rehabilitation services for these individuals. The Council also monitors, reviews, evaluates, and advises the allocation and adequacy of mental health services within the state.

The Planning Council members and committees were asked to identify topics they wanted information on following each Planning Council meeting. The topics addressed at each meeting were based on the Council members' requests. The Planning Council met: January 29, 2015, April 23, 2015, and July 9, 2015. The next meeting is scheduled for November 12, 2015. At each meeting, the Council has been consistently informed of the status of the Department of Mental Health's budget. Please see the attached Planning Council minutes for information on topics presented this year.

The Council members received information on the application instructions for the draft and final report provided by SAMHSA throughout the plan development process. The process to make a Draft Plan available for review by the Council and the public proceeded along timelines to allow sufficient time for public review and comment and compliance with the federal submission timeline.

The Council received reports on the major initiatives planned for FY 2016-2017 at the January meeting. The State Plan Draft was presented and approved by the Council at the April meeting. The 30 day comment period for the State Plan Draft was June 5, 2015 through July 15, 2015. The Council had the opportunity for further review of the FY 2016-2017 State Plan Draft during this time. The Council voted and approved the plan at the July meeting.

The FY 2016-2017 State Plan Draft was presented to the Board of Mental Health at the June 18, 2015 board meeting. The FY 2016- 2017 State Plan was presented and approved by the Board of Mental Health at the July 16, 2015 board meeting.

Public notices of the availability of the Draft Plan for 30 days' public review and comment was made available at the 14 regional community mental health centers across the state, the East MS State Hospital in Meridian, the MS State Hospital in Whitfield, the North MS State Hospital in Tupelo, the South MS State Hospital in Purvis, the Central MS Residential Center in Newton, the five regional centers for persons with intellectual developmental disabilities, the Specialized Treatment Facility and the Mississippi Adolescent Center operated by the Department of Mental Health and on the MS Department of Mental Health's website. A Draft Plan was sent directly to the directors of the community mental health centers and the Department of Mental Health facilities asking them to make the Plan available to their employees and other interested individuals in their area of the state. The Draft Plan was also sent to all members of the MS Planning and Advisory Council.

In addition to those entities listed in the public notice, the Draft Plan and requests for review, comment, and assistance in making the Plan accessible for review and comment were sent directly to Governor Phil Bryant and the directors of the following agencies:

MS Department of Education  
MS Department of Health  
MS Department of Human Services

MS Department of Human Services, Division of Aging and Adult Services  
Disability Rights Mississippi, Inc.  
MS Department of Rehabilitation Services  
MS Institutions of Higher Learning  
Office of the Governor, Division of Medicaid  
Mississippi Development Authority  
Department of Psychiatry and Human Behavior, University of MS Medical Center  
MS Primary Health Care Association  
Melody Worsham, Certified Peer Support Specialist

Although some non-service representatives on the Planning Council are also members of NAMI chapters, Mental Health Associations and/or Mississippi Families As Allies for Children's Mental Health, Inc., additional copies of the Draft Plan and requests for comment were also sent to directors, presidents, or other leadership of state and local affiliates of the following family/consumer/advocacy groups:

Mississippi Families as Allies for Children's Mental Health, Inc.  
Mental Health Association of Mississippi  
NAMI Mississippi

The Planning Council continues to be expanded to include representatives of all populations. Several African Americans and senior adults currently serve on the Council. A representative from the Hispanic community, a representative from the Mississippi Band of Choctaw Indians, and two adolescents also serve on the Council.

The Bureau of Alcohol and Drug Services is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems. The overall goal of the state's alcohol and drug service system is to provide a continuum of community-based primary and transitional residential treatment, inpatient and recovery support services.

The Councils for Alcohol and Drug Services and Mental Health are not combined at this time. However, two representatives from the Alcohol and Drug Services Advisory Council also serve on the Mental Health Planning and Advisory Council. The Bureau of Community Services and the Bureau of Alcohol and Drug Services work together in developing the State Plan.

The MS Department of Mental Health Community Mental Health Services FY 2015-2016 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission.

# **SECTION V**

# **ATTACHMENTS**

# APPENDIX A

# APPENDIX B

# APPENDIX C

# APPENDIX D

# APPENDIX E

# APPENDIX F