MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMMUNITY MENTAL HEALTH SERVICES FY 2014 – 2015 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: Edwin

Last Name: LeGrand III

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

Fax: 601-359-6295

Email Address: ed.legrand@dmh.state.ms.us

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

From: 7/1/2011

To: 6/30/2012

IV: Date Submitted

Submission Date:

Revision Date:

V. Contact Person Responsible for Application Submission

First Name: Jake

Last Name: Hutchins

Telephone: 601-359-1288

Fax: 601-359-6295

Email Address: jake.hutchins@dmh.state.ms.us

PHIL BRYANT
GOVERNOR

February 25, 2013

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

Dear Ms. Simmons:

I hereby certify that the Mississippi Department of Mental Health is designated as the state agency to administer the Community Mental Health Services (CMHS) Block Grant in Mississippi. I have designated Mr. Edwin C. LeGrand III, Executive Director of the Mississippi Department of Mental Health, to apply for the block grant and to sign all assurances and certifications required by federal law and application guidelines.

If you have any questions, please contact Mr. LeGrand or Mr. Jake Hutchins, Director of the Bureau of Community Services, at (601) 359-1288 or by e-mail at jake.hutchins@dmh.state.ms.us.

Sincerely,

Phi Bryant
GOVERNOR

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Edwin C. LeGrand III
Title	Executive Director
Organization	Mississippi Department of Mental Health

Signature: Edw. C. LeGrand Date: 5/20/13

Footnotes:

Signed copy by Edwin C. LeGrand III, Executive Director of the Mississippi Department of Mental Health, is in the attachments.

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Edwin C. LeGrand III
Title	Executive Director
Organization	Mississippi Department of Mental Health

Signature: Edwin C. LeGrand III Date: 9/26/13

Footnotes:

Signed copy by Edwin C. LeGrand III, Executive Director of the

I: State Information

Chief Executive Officer's Funding Agreements/Certification (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2014

I hereby certify that Mississippi agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name

Title

Organization

Signature: _____ Date: 9/20/13

Footnotes:

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
MISSION STATEMENT

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

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 abuse and dementia has disappeared.
- Research, outcomes 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 Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. 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: Assess the Strengths and Needs of the Service System

Overview of the State Mental Health System

The State Public Mental Health Service System

The public mental health system in Mississippi is administered by the Mississippi Department of Mental Health (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.

Organizational Structure of the Mississippi Department of Mental Health

The structure of the DMH is composed of three interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-operated Programs and Community Services Programs.

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

Department of Mental Health Central Office – The Executive Director directs all administrative functions and implements policies established by the State Board of Mental Health. The DMH has a state Central Office for administrative, monitoring and service areas. The Division of Legal Services and the Director of Public Information report directly to the Executive Director.

The DMH has six bureaus: the Bureau of Administration, the Bureau of Mental Health, the Bureau of Community Mental Health Services, the Bureau of Alcohol and Drug Services, the Bureau of Intellectual and Developmental Disabilities and the Bureau of Quality Management.

The Bureau of Administration works in concert with the Bureau of Mental Health and the Bureau of Community Services to administer and support development and administration of mental health services in the state. The Bureau of Administration includes the following divisions: Division of Accounting, Division of Audit and Grants Management, and the Division of Information Systems.

The Bureau of Community Mental Health Services has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's disease/other dementia. The Bureau of Community Services provides a variety of services through the following divisions: Division of Children and Youth Services, Division of Adult Grants Management, 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 abuse problems, including state Three-Percent Alcohol Tax funds for DMH. The overall goal of the state's alcohol and drug 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 services. The Bureau includes two divisions, the Division of Prevention Services and the Division of Treatment Services.

The Bureau of Mental Health oversees the six state behavioral health programs which include public inpatient services for individuals with mental illness and/or alcohol/drug issues as well as the Central Mississippi Residential Center.

The Bureau of Intellectual and Developmental Disabilities is responsible for the 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 programs for individuals with intellectual and developmental disabilities, one juvenile rehabilitation program for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services. The Bureau of IDD includes three divisions, the Division of Home and Community-Based Services, the Division of Housing and Community Living and the Division of Transition Services.

The Bureau of Quality Management is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH standards, development of the peer review system as a part of DMH's overall quality management system, provision of support to programmatic divisions/bureaus with 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, oversight of constituency services and the future development of agency and provider performance measures. The Bureau is comprised of the Office of Consumer Support, the Division of Disaster Preparedness and Response and the Division of 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, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health.

Service Delivery System

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

State-operated programs: The DMH administers and operates six state behavioral health programs, five regional programs for people with IDD, and a juvenile rehabilitation program. These programs serve specified populations in designated counties/service areas of the State.

The behavioral health programs provide inpatient services for people (adults and children) with SMI. These programs include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, Specialized Treatment Program and Central Mississippi Residential Center. Nursing program services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital.

The Intellectual and Developmental Disabilities programs provide on-campus residential services for persons with intellectual and developmental disabilities. These programs include Boswell Center, Ellisville State School, Hudspeth Center, North Mississippi Center, and South Mississippi Center.

The Mississippi Adolescent Center (MAC) in Brookhaven is a residential program dedicated to providing adolescents with intellectual and developmental disabilities an individualized array of rehabilitation service options. MAC serves youth who have a diagnosis of intellectual and developmental disabilities and whose behavior makes it necessary for them to reside in a structured therapeutic environment. The Specialized

Treatment Program in Gulfport is a Behavioral Health Residential Treatment Program for adolescents with mental illness and a secondary need of substance abuse prevention/treatment.

State-operated Community Service Programs: All of the Behavioral Health Programs and IDD programs provide community services in all or part of their designated service areas. Community services include: residential, employment, in-home, and other supports to enable people to live in their community.

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

Other Nonprofit/Profit Service Agencies/Organizations: These agencies and organizations make up a smaller part of the service system. They are certified by the DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol 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 MS Department of Mental Health is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in and/or facilitates numerous avenues for ongoing communication with consumers, family members and services providers.

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

The MS Department of Mental Health is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance abuse services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; 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 **V. Support of State Partners.**

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS	
Region 1: Coahoma, Quitman, Tallahatchie, Tunica	Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267
Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	Region III Mental Health Center Robert Smith, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662) 844-1717
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	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
Region 5: Bolivar, Issaquena, Sharkey, Washington	Delta Community Mental Health Services Doug Cole, Executive Director 1654 East Union Street P. O. Box 5365 Greenville, MS 38704-5365 (662) 335-5274
Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower	Life Help Madolyn Smith, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211
Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston	Community Counseling Services Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347

Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	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.)
Region 9: Hinds	Hinds Behavioral Health Margaret L. Harris, Executive Director 3450 Highway 80 West P.O. Box 777Jackson, MS 39284 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	Southwest MS Mental Health Complex Steve Ellis, Ph.D., Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jeff Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Jeffrey L. Bennett, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Mental Health Services Steve Roark, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Strengths and Needs of the Service System

Strengths: Children with serious emotional disturbance (SED) and their families

- The Mississippi Transitional Outreach Program (MTOP), a Children's Mental Health Initiative targeting transitional-age youth, 14-21 years, entered into the fourth year of implementation on October 1, 2012. 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.

- A commitment to an interagency, collaborative approach to system development and improvement, both at the state and local levels, has remained inherent in efforts to build and transform the system over time. New legislation expanding the ICCCY and ISCC was passed in March 2010 with provisions for increased local participation from agencies on local MAP Teams. The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances with complex needs that usually require the intervention of multiple state agencies. The DMH provides flexible funding to this state-level team and to local interagency Making A Plan (MAP) teams that are designed to implement a wrap-around approach to meeting the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Human Services (DHS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services, as well as adolescent offender programs across the state.

- The DMH and the Division of Children's Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training of staff from other child and family support service agencies. Collaborative training initiatives include Wraparound 101 and System of Care by staff at the Innovations Institute at the University of Maryland; MAP team development and expansion; Youth Suicide Prevention; Cultural Diversity; Trauma-Informed Care; juvenile mental health issues; and cross - system improvement trends and best practices.

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. Several state and local agencies participated in a Policy Academy focusing on co-integrated treatment (SED and Alcohol/Drug Abuse) for youth involved in the juvenile justice system. The Director of the Division of Children and Youth is directly involved with the development of standards for Mississippi's youth detention centers. The DMH continues to fund CMHCs for the provision of mental health services in the local detention centers.

- Efforts have been initiated to provide training in evidence-based practices to clinicians in the CMHCs and other nonprofit programs to improve responses to youth and families in crisis, including those with a history of trauma.

- The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in

rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges.

- The DMH received a one-year System of Care Expansion Planning Grant in July 2012. This grant focuses on the development of a Strategic Plan as well as the infrastructure for the provision of services and resources for children, birth to 5 years of age.

Needs: Children with serious emotional disturbance (SED) and their families

- The need to decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers.

- The need to address children with co-occurring disorders of serious emotional disturbance and intellectual and developmental disabilities in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross system collaboration and education.

- Continuing work to improve the information management system is needed to increase the quality of existing data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Availability of additional workforce, particularly psychiatric/medical staff at the local community level, who specialize in children's services, is an ongoing challenge in providing and improving services.

- Continuing to work on expansion of the new services in the State Medicaid Plan Amendment including Wraparound Facilitation, Intensive Outpatient Psychiatric Services, Peer to Peer Support Services and Community Support Services.

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 developed a range of community-based service options that can be accessed to address the individualized and changing needs of individuals with serious mental illness.

- The DMH has maintained a long-term commitment to improve its system of crisis response and continuity of care for individuals who have been or who are at risk for hospitalization. Addressing this issue requires multiple strategies and –interaction with local courts around civil commitment. Individuals and families in crisis frequently lack financial resources, as well as the limited resources of many local communities to address emergency care needs. The DMH has created the Division of Crisis Response to address the development of crisis response capabilities in the state. The community mental health center regions are required to provide 24 hour a day face-to-face or telephone crisis response depending on the nature of the crisis. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

- Regionalization of acute care/crisis services has been advanced through the opening of two, 50 bed acute psychiatric hospitals for adults to serve the northern and southern areas of the state. The DMH funds seven (7) sixteen (16) bed Crisis Stabilization Units and partially funds one (1) twenty-four (24) bed Crisis Stabilization Unit throughout the state. The DMH also partially funds one (1) six (6) bed crisis stabilization unit for adolescents. Timber Hills Community Mental Health Center, in Region 4, also operates a sixteen (16) bed CSU for adults without funding from the DMH**.** The community mental health center regions do not operate one (1) of the crisis stabilization units. All Crisis Stabilization Units take voluntary as well as involuntary admissions.

- The DMH Division of Community Services and the DMH Bureau of Alcohol and Drug Services has a history of consensus and collaboration in continuing efforts to better address the needs of individuals with co-occurring mental illness and substance abuse disorders. The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. Timber Hills Community Mental Health Center, in collaboration with surrounding counties, opened a CSU which is also certified by the DMH to provide detoxification services.

- 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 Division of Consumer Support 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 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.

- Efforts to address outreach and specialized approaches that are more responsive to the needs of individuals with serious mental illness who are homeless have involved ongoing collaboration and creativity among the DMH and other agencies and organizations that serve homeless persons. The DMH is actively collaborating with The Social Security Administration, Disability Determination Services, Veterans Affairs and other organizations to plan and implement SOAR Training for various regions across the state. Mississippi has been selected to participate in the national SOAR evaluation process and is contributing SOAR data from PATH and other providers on the Gulf Coast. The long-term goal is to have a SOAR-trained case manager in each of the community mental health centers in the state to ensure full access to SSI/SSDI benefits by individuals with serious mental illness who are homeless or at imminent risk for becoming homeless.

- In 2012, the DMH created the Division of Housing and Community Living and appointed a Director of this new Division who is vested with the responsibility to help lead the efforts to expand and enhance availability and access to fully integrated community living for individuals with serious mental illness and other disabilities who wish to and are able to be supported in the community.

- The Office of Consumer Support 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 abuse, and intellectual/developmental disabilities.

- The Mississippi Department of Mental Health, 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 Office of Consumer Support (OCS) 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 OCS 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 Division of Alzheimer's Disease and Other Dementia provides awareness and educational programs, 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 adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services.

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

- The DMH continues its involvement with the Mississippi Transportation Coalition, which was established to bring diverse transportation stakeholders to the table to work together in creating a plan for a coordinated human transportation system for Mississippi. The Coalition is dedicated to creating a coordinated, accessible, affordable, dependable, flexible, safe and environmentally friendly statewide system which provides the best transportation services to every Mississippian.

- The DMH has dedicated a small amount of funds toward funding a pilot transportation project at Life Help Community Mental Health Center. Funds have been used to provide enhanced transportation services (including evenings and weekends) to a limited number of the center's residential program participants. This pilot has offered the opportunity to engage an additional transportation service provider in the center's catchment area. Efforts are under way to stabilize the use of this provide r by enlisting new transit customers from the community at large.

- The need for increased supported and independent employment options for adults with serious mental illness is ongoing.

- 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 CMHC regions to provide training to law enforcement and has also explored several funding opportunities 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. Plans to enhance existing intensive supports and develop new protocols for follow-up services and aftercare are being developed.

- 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 a new and existing data into a comprehensive quality improvement system.

Step 2: Identification of the Unmet Service Needs and Critical Gaps

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 through 17 years in Mississippi in 2009 is 375,918. Mississippi remains in the group of states with the highest poverty rate (21.5% age 5-17 in poverty, based on 2008 Federal poverty rates), therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2009 are as follows:

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

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 (134,710**), yielding an estimated prevalence of 12,393 in this transition age group. According to the 2003-2006 National Survey on Drug Use and Health (NSDUH), in Mississippi, 9,000 males and 8,000 females abused or were dependent on alcohol or drugs in the past year. Approximately 9,000 Mississippi adolescents (12 to 17 years) needed but did not receive treatment for alcohol problems or for past-year drug problems (SAMHSA, Office of Applied Studies, September 2009).

In FY 2009, 30,199 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, FY 2011).

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 2,168,103, based on U.S. Census 2009 population estimates. According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 117,078 in 2009.

In FY 2009, 53,910 adults with serious mental illness were served through the public community mental health system in Mississippi. Services were provided in all 15 mental health regions and by the community services division of one psychiatric hospital to 9,295 individuals with co-occurring disorders (Mississippi State Plan for Community Mental Health Services, FY 2011.) According to the 2003-2006 National Survey on Drug Use and Health (NSDUH), the rates of individuals ages 18-25 who need drug treatment were below the national average, and the rates of individuals who need alcohol treatment are among the

lowest in the country (SAMHSA, Office of Applied Studies, December 2008).

Data and other information used to identify unmet needs/critical gaps in the service system are obtained from a variety of sources and processes.

The DMH administrative staff evaluate the status of the system against national trends and reports, such as the Report of the President's New Freedom Commission on Mental Health (July 2003), SAMHSA's Strategic Initiatives and feedback from State Plan review meetings and on-site monitoring visits. Similarly, staff review and consider feedback received through annual external review of the State Plan by the Planning and Advisory Council and the State Board of Mental Health.

The DMH tracks progress on specific, annual objectives that are steps toward broader system goals to increase services or enhance existing services within service systems. Progress on these objectives is tracked by analyzing aggregate reports of administrative data received from local community service providers and data maintained by Central Office staff within an internal report system (reports of on-site visits to service providers, Central office staff activity logs/reports, task force minutes and reports, etc.). Results of site visits, as well as of peer review visits, are documented through a structured reporting and feedback system that includes required plans of compliance that address deficiencies in meeting operational standards set by DMH. The DMH staff make follow-up visits to monitor implementation of approved plans of compliance. Such ongoing, regular visits to local programs are key to identifying unmet needs. Administrative data from the state psychiatric hospitals are also routinely submitted/reviewed by DMH management staff. Efforts to transition to a central data repository system, as well as to integrate consumer and family satisfaction and additional data focusing on system-level and consumer and family-centered outcomes to better evaluate progress on objectives continue. The DMH's federal data infrastructure grant is being used to support much of this work.

The DMH also continues to gain direct feedback on unmet needs from family members, consumers, local service providers, and representatives from other agencies through numerous task forces and coalitions that focus on critical issues. The DMH has also benefited greatly from the continuity of its relationship with the MS State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH is implementing statewide consumer and family (for children) satisfaction surveys as another means of collecting feedback from individuals served by the system.

In addition to considering estimates of prevalence for 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 Division of Children and Youth Services gains additional information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan

(MAP) teams, and through the work of the State-level Interagency Case Review Team, the Interagency Coordinating Council for Children and Youth (ICCCY), and two Comprehensive System of Care Projects, commUNITY cares and the Mississippi Transitional Outreach Program described in more detail in the State Plan.

The DMH management staff receive 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.

Step 3: Prioritize State Planning Activities

Table 2 Plan Year FY 2014-2015:

	State Priorities
1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
2	Interagency Collaboration for Children and Youth with SED
3	Expansion of System of Care for Children and Youth with SED
4	Integrated Services for Children and Youth with SED
5	Recovery Supports (Combined – SMHA/SSA)
6	Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined – SMHA/SSA)
7	Integration of Behavioral Health and Primary Care Services (Combined – SMHA/SSA)
8	Trauma (Combined – SMHA/SSA)
9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
10	Targeted Services to Rural and Homeless Adults with SMI
11	Management Systems

Step 4: Objectives, Strategies and Performance Indicators

The primary target populations addressed in the FY 2014-2015 State Plan are children with serious emotional disturbances (SED) and adults with serious mental illness (SMI).

State Priority 1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

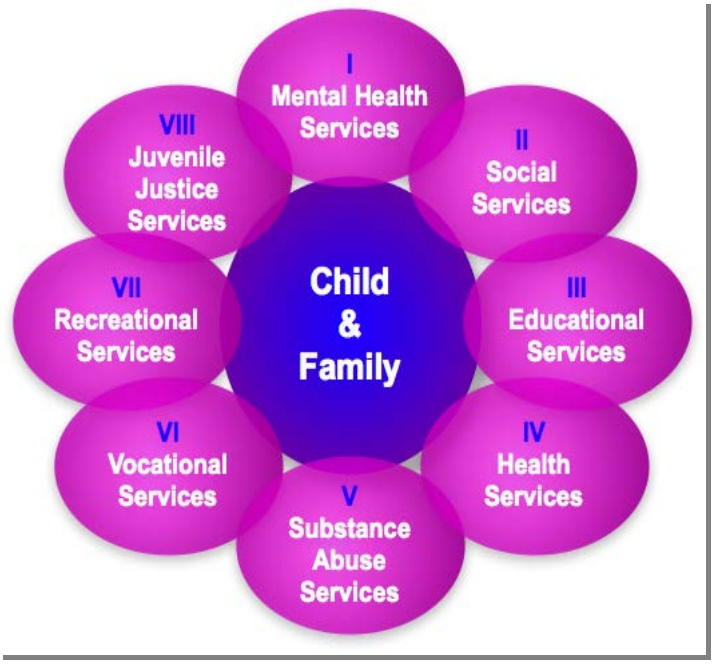
Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living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

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 15 regional mental health/mental retardation commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, family education and respite and prevention/early intervention services. Public inpatient services are provided directly by the MS Department of Mental Health (described further later under this criterion). The Department of Mental Health remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Acute Inpatient Services, Medication Maintenance, Respite Services, 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. Psychological and developmental evaluations, services for children under age three (3), day treatment services, and services in excess of service standard must be prior authorized by the Division. The service standards are: Individual therapy, 36 visits per year, family therapy, 24 visits per year, and group therapy, 40 visits per year.

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 and community – based resources. 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 child-serving agencies: MS Department of Education, MS Department of Mental Health, State Department of Health, Department of Human Services, Division of Medicaid (Office of the Governor), State Department of Rehabilitation Services and Mississippi Families As Allies for Children's Mental Health, Inc. 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 MSFAA. 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.

The most recent System of Care legislation, HB 1529 passed in 2010 Legislative Session, revised and expanded the ICCCY and ISCC membership. The new membership includes representatives from the Attorney General's office, MAP Team Coordinator, Child and Adolescent Psychiatry, the ARC of MS, faculty member from a local University, Early Childhood Development/Education, youth and an additional parent/family member. These three bodies (ICCCY, ISCC, MAP Teams) provide for the development and implementation of a coordinated interagency system of necessary services and care for children and youth up to age 21 with serious emotional/behavioral disturbances who require services from multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

Goal 1: To continue availability of funding for three prevention/specialized early intervention programs

Strategy: The DMH will continue to provide funding for three prevention/specialized early intervention programs for children/youth with SED identified by this program. These children/youth receive prompt evaluation and referrals, and appropriate therapeutic intervention to address the abuse; parents receive effective parenting skills training and family interventions, as well as other interventions designed to reunify and/or improve family relationships where possible.

Performance Indicator: The number of programs to which DMH makes available funding to help support prevention/early intervention **(**three**)**

Baseline Measurement: In FY 2012, the DMH continued to provide funding to Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center. These two programs served 293 children and 113 families in FY 2012.

First-Year Target/Outcome Measure: In FY 2014, the DMH will provide funding for three prevention/specialized early intervention programs.

Second-Year Target/Outcome Measure: In FY 2015, the DMH will provide funding for three prevention/specialized early intervention programs.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH RFPs/grant applications/grants

*__Footnote:__ Prevention services supported through state funds from the DMH and provided to these families include: home visits, prenatal education, parenting education classes, preschool classes, sibling intervention groups, and specialized multidisciplinary sexual abuse prevention programs. The DMH also has a representative on the State Board for the Children's Trust Fund, which support projects across the state and provides financial assistance for direct services to prevent child abuse and neglect and to promote a system of services, laws, practices and attitudes that enable families to provide a safe and healthy environment for their children.

Goal 2: To continue to provide technical assistance through the Division of Children and Youth Services to encourage providers to make children's mental health services available to serve infants and young children, birth to 5 years of age

Strategy: Technical assistance will be provided by the Division of Children and Youth Services staff and other experts in the field upon request, including on-site visits, to providers interested in developing children's mental health services to serve children, birth to 5 years of age, with mental health issues and their families.

Performance Indicator: The DMH Division of Children and Youth Services staff will assist in coordinating technical assistance to service providers on developing mental health services for children, birth to 5 years of age.

Baseline Measurement: In FY 2012, three CMHCs had five specialized day treatment programs for children ages 3 to 5 years. In FY 2012, a total of 4,691 children and youth were served in 353 day treatment programs in school-based and center-based sites across the state.

First-Year Target/Outcome Measurement: In FY 2014, all providers developing mental health services for infants and children, birth to 5 years of age, will receive technical assistance when requested.

Second-Year Target/Outcome Measurement: In FY 2015, all providers developing mental health services for infants and children, birth to 5 years of age, will receive technical assistance when requested.

Description of Collecting and Measuring Changes in Performance Indicator:
DMH Division of Children and Youth Services monthly staffing report forms

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Goal 3: To continue availability of school-based general outpatient mental health services (other than day treatment)

Strategy: Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families will be provided. Current DMH Operational Standards require all CMHCs to offer and if accepted, maintain interagency agreements with each local school district in their region, which outline the provision of school-based services to be provided by the CMHCs.

Performance Indicator: Number of regional CMHCs through which general outpatient services for children with serious emotional disturbance are made available (offered) to schools (Offered by 15 CMHC Regions)

Baseline Measurement: In FY 2012, a total of 27,503 children were reported as having received outpatient services through the 15 community mental health centers (center-based and school-based sites), including individual, group, or family therapy services. There were 17, 155 children and youth served in 657 school-based sites by 448 school based therapists during FY 2012.

First-Year Target/Outcome Measurement: In FY 2014, All 15 CMHCs will offer school-based general outpatient mental health services.

Second-Year Target/Outcome Measurement: In FY 2015, all 15 CMHCs will offer school-based general outpatient mental health services.

Description of Collecting and Measuring Changes in Performance Indicator: The DMH Division of Children and Youth Services records/reporting; Annual State Plan Survey

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Goal 4: To continue to make available funding for respite service capabilities

Strategy: The DMH will continue to fund two providers to support the implementation of respite services, which are planned temporary services provided for a period of time ranging from a few hours within a 24-hour period, to an overnight or weekend stay. Respite is a service identified by families and representatives of state child service agencies, as well as other stakeholders, as a high need service for families and children with SED to support keeping youth in the home and community.

Performance Indicator: The number of respite providers available during the year (200)

Baseline Measurement: In FY 2012, MS FAA reported serving 423 children/youth in respite services. Harden House, reported serving 62 children/youth ages seven months to nineteen years in respite services. During FY 2012, there were 152 respite providers available statewide (MS FAA – 74; Harden House – 78).

First-Year Target/Outcome Measurement: In FY, 2014, 100 respite providers will be available statewide.

Second-Year Target/Outcome Measurement: In FY 2015, 100 respite providers will be available statewide.

Description of Collecting and Measuring Changes in Performance Indicator: Annual State Plan Survey

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Goal 5: To continue to provide funding to assist in providing therapeutic foster care homes to serve children/youth with SED to further develop community-based residential mental health treatment services for children with SED

Strategy: The DMH will continue to provide funding to the evidence-based therapeutic foster care program operated by Catholic Charities, Inc. The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by the DMH.

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

Baseline Measurement: In FY 2012, DMH continued to make funding available to Catholic Charities, Inc to help support licensed therapeutic foster care homes. Catholic Charities provided therapeutic foster care to 27 youth in FY 2012. Additionally, five

nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 153 youth.

First-Year Target/Outcome Measurement: In FY 2014, twenty-four children/youth will receive therapeutic foster care services through Catholic Charities, Inc., funded by DMH.

Second-Year Target/Outcome Measurement: In FY 2015, twenty-four children/youth will receive therapeutic foster care services through Catholic Charities, Inc., funded by DMH.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Program grant reports

***Footnote:** Therapeutic Foster Care (TFC) Services continue to be an important community-based component, particularly for children with serious emotional disturbance in the custody of the Department of Human Services. The model utilized in Mississippi employs trained therapeutic foster parents with only one child or youth with SED placed in each home. The DMH continues to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. Additional youth are served in therapeutic foster care funded by other agencies, including the Department of Human Services.

Goal 6: The DMH funding will continue to be made available for nine therapeutic group homes for children and youth with serious emotional disturbance.

Strategy: The DMH will continue to provide funding to support therapeutic group homes. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

Performance Indicator: The number of therapeutic group homes for which the DMH provides funding support (nine)

Baseline Measurement: In FY 2012, the DMH continued to make funding available for nine therapeutic group homes. A total of 298 children and youth with serious emotional disturbances were served by therapeutic group homes receiving funding from DMH. Also, an additional 215 youth were reported as served through therapeutic group homes certified, but not funded by DMH. (Two therapeutic group homes operated by Southern Foundation for Homeless Children and one therapeutic group home operated by Center for Family Life Extension did not submit data.)

First-Year Target/Outcome Measurement: In FY 2014, the DMH will make funding available for nine therapeutic group homes.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will make funding available for nine therapeutic group homes.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Residential Monthly Summary Forms/Grant Proposals from the existing DMH-funded therapeutic group home providers

Goal 7: To evaluate children with serious emotional disturbance who receive substantial public assistance for Community Support Services and to offer these services to families

Strategy: Evaluation services will be provided to determine the need for Community Support Services, as documented in the record, for children with serious emotional disturbance who are receiving Medicaid and are served through the public community mental health system.

Performance Indicator: Number of children with serious emotional disturbances who receive Community Support Services

Baseline Measurement: In FY 2012, 14,850 children with serious emotional disturbance were reported as having received case management services through the CMHCs. In FY 2012, 306 CMHC case managers provided services to children/youth with SED.

First-Year Target/Outcome Measurement: In FY 2014, 13,125 children/youth with serious emotional disturbance will receive Community Support Services.

Second-Year Target/Outcome Measurement: In FY 2015, 13,125 children/youth with serious emotional disturbance will receive Community Support Services.

Description of Collecting and Measuring Changes in Performance Indicator:
Compliance will be monitored through the established on-site review/monitoring process

***Footnote:** The following children/youth with serious emotional disturbances must be evaluated for the need for Community Support Services and provided with Community Support Services if needed, based on evaluation, unless the service has been rejected in writing by the parent(s)/legal guardian(s): children/youth with SED who receive substantial public assistance; children/youth with SED who are receiving intensive crisis intervention services; and, children/youth referred (within two weeks) to the CMHC after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes.

Goal 8: To continue to make funding available for Crisis Stabilization Services for youth with serious emotional disturbance or behavioral disorder who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement

Strategy: The DMH will continue funding to Catholic Charities for a comprehensive Crisis Stabilization Program for youth with serious emotional disturbance or behavioral disorders and who otherwise are imminently at-risk of out-of-home/community placement.

Performance Indicator: Number of youth served in the program

Baseline Measurement: In FY 2012, the DMH continued to fund five comprehensive crisis response programs for youth with SED or behavioral disorders. This goal has been modified. No data currently exists.

First-Year Target/Outcome Measurement: In FY 2014, 75 children/youth will be served in the Crisis Stabilization Program.

Second-Year Target/Outcome Measurement: In FY 2015, 75 children/youth will be served in the Crisis Stabilization Program.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for Catholic Charities

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Goal 9: To continue funds for specialized outpatient intensive crisis intervention capabilities of seven CMHCs

Strategy: The DMH will continue funding specialized outpatient intensive crisis projects (seven).

Performance Indicator: The number of programs that receive DMH funding for specialized outpatient intensive crisis intervention projects (seven)

Baseline Measurement: In FY 2012, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. Region 3 CMHC served 81 youth; Region 13 served 583 youth; Region 15 served 57 youth; Gulf Coast Women's Center served 134 youth; and MS Families as Allies for Children Mental Health, Inc. served 35 youth.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will provide funding for seven specialized outpatient crisis intervention projects.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will provide funding for seven specialized outpatient crisis intervention projects.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Crisis Monthly Summary Forms/Grant Proposals for the specialized programs/monthly cash requests

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Goal 10: To maintain provision of community-based services to children with serious emotional disturbance

Strategy: The DMH will continue to collect data on the total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers.

Performance Indicator: The total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance (52,500). It should be noted that the number of youth targeted to be served in the following objective includes only youth with serious emotional disturbances served through the public community mental health system, which are a subset of the number of youth with any mental illness accessing services in the public community and inpatient system, reported in the NOM.

Baseline Measurement: In FY 2012, 32,105 children with SED were reported to have been served through the regional community mental health centers, and 1,058 children with SED were reported to have been served through other nonprofit providers certified and received funding from DMH; a total of 33,163 youth with SED were served through the

public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.

First-Year Target/Outcome Measurement: In FY 2014, 26,250 children/youth with SED will be served through community mental health centers and other non-profit providers of mental health services.

Second-Year Target/Outcome Measurement: In FY 2015, 26,250 children/youth with SED will be served through community mental health centers and other non-profit providers of mental health services.

Description of Collecting and Measuring Changes in Performance Indicator: Annual State Plan survey; community mental health service provider data.

Goal 11: To improve school attendance for those children and families served by CMHCs

Strategy: School-based therapists employed by the CMHCs will continue to offer and provide as requested mental health services in the local schools, including school-based outpatient and school-based day treatment programs as described in the State Plan.

Performance Indicator: Interagency agreements between schools and CMHCs providing school-based Services will be verified on monitoring visits by the DMH

Baseline Measurement: In FY 2012, at least one outpatient therapist was offered to every public school district in the region served by the CMHC.

First-Year Target/Outcome Measurement: In FY 2014, every public school district in the state will be offered outpatient therapy services by the CMHCs.

Second-Year Target/Outcome Measurement: In FY 2015, every public school district in the state will be offered outpatient therapy services by the CMHCs.

Description of Collecting and Measuring Changes in Performance Indicator: Interagency agreements between schools and CMHCs providing school-based services; site visit documentation

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Goal 12: To continue funding existing programs that serve children who are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness

Strategy: The DMH will continue to provide funding to the MAP Teams, intensive crisis intervention programs, therapeutic foster care programs, and therapeutic group homes.

Performance Indicator: The number of funded programs that serve children who are homeless/potentially homeless through this specialized program (19)

Baseline Measurement: This is a revised goal. No baseline data is available.

First-Year Target/Outcome Measurement: In FY 2014, DMH will provide funding to 19 programs that serve children/youth who are homeless/potentially homeless due to a

variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will provide funding to 19 programs that serve children/youth who are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness.

Description of Collecting and Measuring Changes in Performance Indicator: Grant proposal for existing program. This children's program is required to submit monthly data on the number of children served (targeted above) including the number of children with serious emotional disturbance.

Goal 13: To continue funding to one CMHC for provision of intensive crisis intervention services to youth/families served through a shelter for abused/neglected children

Strategy: The DMH will continue to provide funding to support a CMHC in providing crisis intervention services, a therapist and other needed supports to a local shelter for abused/neglected children.

Performance Indicator: The number of children served through this specialized program (437)

Baseline Measurement: In FY 2012, funding continued to be provided to Region 13 Gulf Coast Mental Health Center to support services to a local shelter for abused/neglected children. The shelter provided services to 535 children in FY 2011; 39 children were enrolled in the services at Region 13 and had a serious emotional disturbance.

First-Year Target/Outcome Measurement: In FY 2014, 218 children/youth will be served through this specialized program.

Second-Year Target/Outcome Measurement: In FY 2015, 218 children/youth will be served through this specialized program.

Description of Collecting and Measuring Changes in Performance Indicator: Grant proposal for the targeted CMHC

Goal 14: To continue to make available technical assistance and/or certification visits in expanding school-based children's mental health services

Strategy: The DMH Division of Children and Youth Services will continue to provide technical assistance regarding the availability of and access to school-based services across CMHC regions. The DMH will continue efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas.

Performance Indicator: Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools (15)

Baseline Measurement: In FY 2012, the DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to 6 CMHC regions (Regions 1,2,4,5,9 and 14).

First-Year Target/Outcome Measurement: In FY 2014, six CMHC regions will receive technical assistance from DMH regarding the expansion of school-based services.

Second-Year Target/Outcome Measurement: In FY 2015, six CMHC regions will receive technical assistance from DMH regarding the expansion of school-based services.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report

***Footnote:** Key to the Department of Mental Health's approach to increasing the accessibility of children's mental health services in rural areas has been expansion of school-based services. Using the school as a base for mental health service delivery is pivotal in facilitating access to services by many youth and families. Providing school-based services also helps address the problem of transportation that exists in rural and other parts of the state.

Goal 15 also addresses State Priority Area 3: Expansion of System of Care for Children and Youth with SED

Goal 15: To further enhance service development and quality of service delivery to minority populations of children and youth with severe behavioral and emotional disorders

Strategy: The DMH requires CMHCs and other DMH-certified programs to offer cultural diversity and/or sensitivity training in accordance with DMH Operational Standards and/or provide cultural competency training to employees.

Performance Indicator: Number of training sessions presented for children/youth service providers that address cultural diversity awareness and/or sensitivity

Baseline Measurement: In FY 2012, NCBI trainings were conducted on July 6, 2011, and July 7, 2011, at the Winston Choctaw Correctional Facility; July 8, 2011, at Region 1 Mental Health Center; South Mississippi Regional Center on October 18, 2011; Communicare on November 16, 2011; January 25, 2012 at the Child Welfare Conference.

First-Year Target/Outcome Measurement: In FY 2014, DMH staff will conduct three trainings for children/youth service providers that address cultural diversity awareness and/or sensibility.

Second-Year Target/Outcome Measurement: In FY 2015, DMH staff will conduct three trainings for children/youth service providers that address cultural diversity awareness and/or sensibility.

Description of Collecting and Measuring Changes in Performance Indicator: DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.

***Footnote:** Division of Children and Youth staff members have attended workshops on Disparities Among Native Americans, Resources for Spanish-Speaking Communities, National Networks of Libraries of Medicine, Eliminating Mental Health Disparities: Challenges and Opportunities, and Lesbian, Gay, Bisexual and Transgender (LGBT) Youth in MS: Why Day of Silence Matters and African-American and LGBT conference.

Goal 16 also addresses State Priority Area 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal 16: To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force

Strategy: Meetings/activities by the Multicultural Task Force will be conducted. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas.

Performance Indicator: The number of meetings of the Multicultural Task Force during FY 2014 and 2015 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council

Baseline Measurement: In FY 2012, the Multicultural Task Force had three meetings. The Multicultural Task Force met on August 19, 2011, November 9, 2011, and March 27, 2012, The task force organized the statewide Day of Diversity which occurred on October 13, 2010 and statewide National Minority Mental Health Awareness event in July 2011. The annual report, presented by a task force member to the Planning Council, was presented on August 13, 2011. The task force members received updates on the Mississippi Transitional Outreach Project (MTOP), Cultural Competency Plan, Cultural Competency Video Conference for leaders presented by Dr. Ken Martinez, Implement Language Access and Strategic Plan. The task force also discussed implementing a language access plan. Task force members attended the "Building a Community of Diversity: Understanding Cultural Competence, Part II conference on September 22 – 23, 2011.

First-Year Target/Outcome Measurement: In FY 2014, the Multicultural Task Force will have at least two meetings.

Second-Year Target/Outcome Measurement: In FY 2015, the Multicultural Task Force will have at least two meetings.

Description of Collecting and Measuring Changes in Performance Indicator:
Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made

***Footnote:** The mission of the Multicultural 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. There are 17 active members on the task force representing various state and local agencies and organizations. The task force has developed a cultural competency plan and has completed the Multicultural Competency Task Force Strategic Map and action plan for several of the strategic initiatives.

Goal 17 also addresses Priority Area 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal 17: To guide the implementation of the Cultural Competency Implementation Workgroup to ensure culturally competency services are provided to individuals receiving services

Strategy: The Cultural Competency Committee/Workgroup will guide the implementation of the Cultural Competency Plan.

Performance Indicator: Meeting/activity by the Cultural Competency Workgroup

Baseline Measurement: In FY 2012, the Department of Mental Health Cultural Competence Implementation Workgroup was established. The workgroup consists of: individuals receiving services, DMH/Division of Adult Services, DMH/Division of Children Services, DMH/Division of IT, DMH/Bureau of Alcohol and Drug Services, DMH/Bureau of IDD and DMH/Division of Prevention Services. The committee met three times this year. The committee has updated the Cultural Competency Action Plans and made changes to the Cultural Competency Implementation Workgroup Strategic Plan.

First-Year Target/Outcome Measurement: In FY 2014, the Cultural Competency Workgroup will have three meetings.

Second-Year Target/Outcome Measurement: In FY 2015, the Cultural Competency Workgroup will have three meetings.

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of the workgroup meetings

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Goal 18: To maintain availability of technical assistance to all existing DMH-certified programs operated by the 15 community mental health centers and non-profit agencies in support of service development and implementation

Strategy: The DMH Division of Children and Youth Staff will continue to provide technical assistance and provide information on applicable training/education to providers of children's mental health services to facilitate the development and/or implementation of services and/or programs for children with SED.

Performance Indicator: The number and type of technical assistance/support activities and/or training made available to CMHCs/other nonprofit service providers

Baseline Measurement: In FY 2012, trainings in NCBI, FASD, System of Care, Cultural Linguistic Competency, Juvenile Justice, Wraparound Facilitation, MAP Teams, and A.S.I.S.T. were conducted by Division of Children and Youth staff.

First-Year Target/Outcome Measurement: In FY 2014, DMH Division of Children and Youth staff will continue to make available technical assistance/support activities and/or training to CMHCs/other non-profit service providers.

Second-Year Target/Outcome Measurement: In FY 2015, DMH Division of Children and Youth staff will continue to make available technical assistance/support activities and/or training to CMHCs/other non-profit service providers.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children and Youth Services monthly activity reports

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Goal 19 also addresses State Priority Area 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal 19: To address the stigma associated with mental illness through a mental illness awareness campaign

Strategy: The DMH will continue to lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the mental illness awareness campaign.

Performance Indicator: Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers (200,000). The DMH will also track the number of live interviews and presentations

Baseline Measurement: In FY 2012, 55 presentations were conducted. More than 100,000 brochures have been distributed since 2008 and more than 10,000 potty posters have been distributed to schools across the state. Mississippi teachers are now required to participate in suicide prevention treatment.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.

Description of Collecting and Measuring Changes in Performance Indicator: Media and educational presentation tracking data maintained by DMH Director of Public Information

***Footnote:** In 2010, 104 presentations were conducted with parents, teachers, and students. In 2011, 132 presentations were conducted. In 2012, 55 presentations were conducted. Mississippi teachers are now required to participate in suicide prevention treatment. Since 2010, more than 55,000 teachers, parents and students have been reached via presentations.

Goal 20 also addresses State Priority Area 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

Goal 20: To review CMHC Policy and Procedure Manuals to ensure adherences to the cultural and linguistic competency mandates required in the DMH Operational Standards and other mandates for federally funded programs

Strategy: Review of the CMHC Policy and Procedure manual will provide an opportunity for CMHCs to develop and implement policies and procedures in the area of cultural and linguistic competence that will enhance service delivery for all. The DMH Operational Standards for Community Mental Health/Mental Retardation Services continue to require that all programs certified by DMH train newly hired staff in cultural diversity/sensitivity within 30 days of hire and annually thereafter. Compliance with standards continues to be monitored on site visits.

Performance Indicator: Staff in the Division of Children and Youth will review a minimum of two (2) CMHC Policy and Procedure Manuals per year

Baseline Measurement: In FY 2012, the review of the Weems Mental Health Center Policy and Procedure Manual was conducted. Technical Assistance was provided regarding the review in November 2012.

First-Year Target/Outcome Measurement: In FY 2014, staff in the Division of Children and Youth Services will review a minimum of two (2) CMHC Policy and Procedure manuals for compliance with DMH Operational Standards regarding CLC requirements.

Second-Year Target/Outcome Measurement: In FY 2015, staff in the Division of Children and Youth Services will review a minimum of two (2) CMHC Policy and Procedure manuals for compliance with DMH Operational Standards regarding CLC requirements.

Description of Collecting and Measuring Changes in Performance Indicator: A summary of the findings and additional development of policies and procedures will be generated.

State Priority 2: Interagency Collaboration for Children and Youth with SED

Interagency collaboration and coordination 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, and participation in a variety of state-level interagency.

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, 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 MS Families As Allies for Children's Mental Health. 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 more than one out-of-home psychiatric treatment, 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 will have priority.

Making A Plan (MAP) Teams employ a systems-based wraparound approach in developing a family-centered multi-disciplinary plan, are designed to address individual needs and build on the strengths of youth and their families. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county human services (family and children's social services) staff, 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. The wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 15 community mental health regions across the state. Sixty-six counties either have a MAP Team or access to one, and all 47 MAP Teams continued to operate statewide and had accessibility to flexible funds.

Department of Mental Health staff participates in a variety of state-level interagency collaboration activities and provide support for interagency collaboration at the local level in the 15 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).

Goal 1: To provide mental health representation on the executive level Interagency Coordination Council for Children and Youth (ICCCY) and the mid-management level Interagency System of Care Council (ISCC), as required by recent legislation

Strategy: The DMH will continue to be represented on the executive level ICCCY and the mid-level Interagency System of Care Council, in accordance with House Bill 1529 and continue participation in activities by both Councils to facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels).

Performance Indicator: Minutes of meetings and related documentation of Attendance by DMH representatives at meetings scheduled in FY 2014 and FY 2015

Baseline Measurement: The Executive Director of the Division of Medicaid serves as the chair of the ICCCY, and the Director of Youth Services (DHS) serves as the chair of the ISCC. The ICCCY met November 1, 2011, to receive an update on System of Care activities such as updates on commUNITY cares, Mississippi Transitional Outreach Program and MYPAC. The ISCC met on October 19th and December 12th in 2011 and on April 5, 2012, to discuss projects, coordinate trainings/conferences, and discuss Cultural/Linguistic Competency, review data from MAP Team quarterly reports, submit a SOC Planning Grant and to discuss sustainability of MYPAC and MTOP.

First-Year Target/Outcome Measurement: In FY 2014, minutes of the ICCCY and mid-level Interagency System of Care Council meetings will be recorded.

Second-Year Target/Outcome Measurement: In FY 2015, minutes of the ICCCY and mid-level Interagency System of Care Council meetings will be recorded.

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of the ICCCY and the Division of Children and Youth Services Monthly Calendar and minutes of the mid-level Interagency System of Care Council and revised Interagency Agreement

***Footnote:** Additional members added to the ICCCY include a representative from the Attorney General's office, a MAP Team Coordinator, a parent of youth with SED, a youth, child psychiatrist, a faculty member from the University of MS Medical Center, Director of the ARC of MS and an early childhood development expert

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Goal 2: To continue operation of the State-Level Interagency Case Review/MAP Team for the most difficult to serve youth with serious emotional disturbance who need services of multiple agencies

Strategy: The State-Level Interagency Planning and Case Review Team will continue to meet monthly to review cases and to address the needs of some youth with particularly severe or complex issues. The team targets those "most difficult to serve" youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home (in-state) or out-of-state placement. The youth reviewed by the team typically have a history of more than one

out-of-home psychiatric treatment and appear to have exhausted all available services/resources in the community and/or in the state. The team develops a recommended resource identification and accessibility plan, which might include formal existing services and informal supports; monitors and tracks implementation of the recommended service plan and the status of the child/youth; and, uses information about the availability of needed services, success of services, and other pertinent information in planning efforts.

Performance Indicator: Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases

Baseline Measurement: In FY 2012, the State-Level Case Review/MAP Team met monthly at the Mississippi Department of Human Services.

First-Year Target/Outcome Measurement: In FY 2014, the State-Level Case Review/MAP Team will meet monthly to review referred cases and provide follow-up on cases previously reviewed.

Second-Year Target/Outcome Measurement: In FY 2015, the State-Level Case Review/MAP Team will meet monthly to review referred cases and provide follow-up on cases previously reviewed.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report and State Level Case Review Team Staffing forms.

***Footnote:** The State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, includes representatives of key child service agencies or programs and of families of children with serious emotional disturbance.

Goal 3: To provide funding for the State-Level Interagency Case Review/MAP Team to purchase critical services and/or supports identified as needed for targeted children/youth with SED reviewed by the team

Strategy: The DMH Division of Children and Youth Services will make funding available to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team**.** The state-level team facilitates a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home. Youth from communities in which there is no local MAP team with funding have priority.

Performance Indicator: Number of children served using this funding for wraparound services

Baseline Measurement: In FY 2012, the State-Level Case Review Team reviewed 6 new cases and provided follow-up on 8 cases. Of the new cases, 1 was diagnosed with Intermittent Explosive Disorder, 1 with Bipolar Disorder, 2 with Mood Disorder, NOS and 1 with ADHD as their primary diagnoses. Two youth had Axis II diagnoses, 1 with borderline intelligence and 1 with Mild Mental Retardation. Of the 6 cases reviewed, 3 youth were transitional age. During this time period, 2 youth returned home from out-of-state facilities.

First-Year Target/Outcome Measurement: In FY 2014, the State-Level Case Review/MAP Team will review referred cases.

Second-Year Target/Outcome Measurement: In FY 2015, the State-Level Case Review/MAP Team will review referred cases.

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of grant award on file at DMH; monthly cash requests

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Goal 4: To continue to provide support and technical assistance in the implementation of Making A Plan (MAP) teams and to further assist in the wrap-around approach to provide services and supports for children/youth with SED and their families

Strategy: The DMH Division of Children and Youth Services will continue to provide support and technical assistance to MAP Teams as requested and/or needed and will **c**ontinue to coordinate meetings with MAP team coordinators to which representatives from the behavioral health center's child/adolescent units and the Department of Human Services representatives are invited.

Performance Indicator: Provision of MAP team local coordinators meetings for networking among MAP teams. Number of technical assistance visits by Division of Children and Youth staff

Baseline Measurement: In FY 2012, the Division of Children and Youth Services Director had coordinated three statewide meetings with the coordinators of local MAP Teams. The following items were discussed: Fetal Alcohol Spectrum Disorders screenings, assessments and trainings; MYPAC updates; collaboration with the Division of Family and Children's Services, Mississippi Department of Human Services; Wraparound 101 and coaching/training process; flexible funds; Intellectual/Developmental Disabilities; NAMI and MS Families As Allies resources and programs. Technical assistance on expansion of MAP Teams was provided to MAP Teams in CMHC Regions 2,3,4,5,6,8, and 10. MAP Team 101 Training was held April 20, 2012, for new MAP Team Coordinators in Regions 1,5,6,10, and 11. DMH Division of Children and Youth staff attended MAP Teams meetings in the following CMHC Regions: 3,4,5,6,8, and 10.

First-Year Target/Outcome Measurement: In FY 2014, MAP Team Coordinators Meetings will be scheduled and Division of Children and Youth staff will provide technical assistance visits to local MAP Teams as requested.

Second-Year Target/Outcome Measurement: In FY 2015, MAP Team Coordinators Meetings will be scheduled and Division of Children and Youth staff will provide technical assistance visits to local MAP Teams as requested.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report and minutes of local MAP team meeting.

***Footnote:** The MAP teams employ a systems-based wraparound approach in developing a family-centered multi-disciplinary plan, designed to address individual needs and build on the strengths of youth and their families. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers**,** county human services (family and children's social services) staff, county youth services (juvenile justice) staff, county health department staff, county rehabilitation services staff and local school staff. Other providers of formal or informal supports, such as youth leaders, ministers or other representatives of children/youth family service organizations in a given community, may

also participate in the planning or service implementation process.

Goal 5: To continue to make available funding for Making A Plan (MAP) Teams

Strategy: The DMH will continue to fund MAP Teams.

Performance Indicator: Number of MAP teams that receive or have access to flexible funding through DMH (47)

Baseline Measurement: In FY 2012, one DMH certified provider in each of the 15 CMHC Regions received a grant from DMH to provide flexible funds for MAP Teams. Sixty-three counties either have a MAP Team or access to a MAP Team. All 47 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 2012, MAP Teams served 1,392 children and youth.

First-Year Target/Outcome Measurement: In FY 2014, all 47 MAP Teams will continue to operate and have access to flexible funds.

Second-Year Target/Outcome Measurement: In FY 2015, all 47 MAP Teams will continue to operate and have access to flexible funds.

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of grant awards; Monthly MAP team reports; monthly cash requests

***Footnote:** Sixty-six counties either have a MAP Team or access to one, and all 47 MAP Teams continued to operate statewide and had accessibility to flexible funds.

Goal 6: To continue to provide information to schools on recognizing those children and youth most at risk for having a serious emotional disturbance or mental illness and on resources available across the state, including services provided by CMHCs

Strategy: The DMH will make available informational materials and technical assistance to local school districts and other individuals/entities by CMHCs, upon request.

Performance Indicator: The number of local schools to which the CMHCs make available informational materials or technical assistance will be documented and available to the DMH, Division of Children/Youth, upon request

Baseline Measurement: In FY 2012, informational materials and technical assistance were provided to 699 local schools by community mental health centers. Topics included available services for children with SED; behavior modification and intervention; crisis management training/MANDT Crisis Intervention Training; mental health diagnoses and identification of signs and symptoms of disorders; medication safety, compliance, and side effects;confidentiality; parenting issues; referral process for services; bullying, truancy, anger management, and violence in the schools; and substance abuse.

First-Year Target/Outcome Measurement: In FY 2014, informational materials and technical assistance will be provided to local school districts by CMHCs as requested.

Second-Year Target/Outcome Measurement: In FY 2015, informational materials and technical assistance will be provided to local school districts by CMHCs as requested.

Description of Collecting and Measuring Changes in Performance Indicator: Annual State Plan Survey

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Goal 7: To continue support for and participation in interagency collaboration activities and other key activities related to infrastructure building as well as make available technical assistance for this development at the state and local levels

Strategy: The DMH Children and Youth Services staff will continue to participate on state-level interagency councils or committees. Interagency collaboration at the state and local levels in planning and training is necessary to develop a more integrated system and to improve continuity of care.

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

Baseline Measurement: In FY 2012, the DMH Division of Children and Youth staff participated on 29 state level interagency councils/committees.

First-Year Target/Outcome Measurement: In FY 2014, the DMH Division of Children and Youth staff will participate on at least 15 state level interagency councils/committees.

Second-Year Target/Outcome Measurement: In FY 2014, the DMH Division of Children and Youth staff will participate on at least 15 state level interagency councils/committees.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report

State Priority 3: Expansion of System of Care for Children and Youth with SED

Children and Youth Services staff continue to participate in interagency meetings and conferences that provide opportunities for increasing awareness across the service system of available children's mental health services. They also continue to disseminate the CYS resource directory through the agency website as well as provide educational materials to individuals at conferences and meetings, the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances.

Provision of Evidence-Based Practices

Mississippi Trauma Recovery for Youth (TRY) Project

The Director of the DMH Division of Children and Youth Services served in an advisory role to the Mississippi Trauma Recovery for Youth (TRY) project, funded through SAMHSA. Catholic Charities, Inc has led this four-year project in the Jackson, tri-county area and the Gulf Coast to raise the awareness about child trauma and to improve access to services for children and youth who have been traumatized. Through partnership with existing community agencies and programs, the project has developed the TRY Network, which is focused on increasing understanding about child trauma, endorsing the use of best practices in serving traumatized children and youth, and promoting collaboration between systems. The TRY Project is also supporting the validation of a strengths-based assessment tool for use with traumatized children and youth**.** TRY of Catholic Charities in Jackson, MS, is a member of the National Child Traumatic Stress Network (NCTSN). The Mississippi Trauma Recovery for Youth (TRY) Project, through a learning collaborative approach has trained clinicians in evidence-based practices such as Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Participants in the collaboratives include clinicians from CMHC regions, the Specialized Treatment Facility, and the MS Band of Choctaw Indians Behavioral Health.

Wraparound Initiatives in Mississippi

The Division of Children and Youth Services partnered with the Division of Medicaid, MYPAC Program to begin state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. Both agencies are using the University of Maryland's Innovation's Institute training model which includes a three-day Wraparound 101 course, one-day Advanced Wraparound and a 12-18 month process for Coach/Supervision Certification.

Goal 1: To promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children with serious emotional disturbances

Strategy: The Division of Children and Youth Services will continue to provide technical assistance and to monitor therapeutic foster care programs certified, but not funded by the DMH. Initiatives to promote implementation of other evidence-based practices for youth and families, such as the Learning Collaboratives for trauma-focused cognitive behavior therapy described in the Plan will also continue. Other local initiatives will also continue;

for example, Region 12 CMHC and Region 13 CMHC have organized workforce training in trauma-focused CBT, CBT and Combined Parent Child CBT for all of their children's therapists, and evidence-based practices for youth are being implemented through the local System of Care project in Region 12.

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

Baseline Measurement: In FY 2012, the Trauma Recovery for Youth Project (TRY) at Catholic Charities, Inc. of Jackson, MS trained clinicians in CMHC Regions 4,5,6,7,10, 11, and 12 in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TRY trained 116 clinicians in 7 CMHC Regions in TF-CBT from July 1, 2011 through July 30, 2012.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children/youth with serious emotional disturbance.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children/youth with serious emotional disturbance.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Program grant reports

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Goal 2: To provide general information/education about children/adolescents "at risk" for or with serious emotional disturbance and about the system of care model (targeting the community at-large, as well as service providers)

Strategy: The DMH will continue to make available current information about children's mental health services through printed material and education by DMH staff as a basic component of ongoing outreach services.

Performance Indicator: Continued production and dissemination of the DMH Division of Children and Youth Resource Directory and other relevant public education material will be made available as needed. Participation in presentations by DMH Children and Youth Services staff at meetings at which public information is provided, as such opportunities are available.

Baseline Measurement: In FY 2012, 221 resource directories were disseminated at confereces , meetings, or to individuals as follows: Mississippi Families As Allies, System of Care Training Participants, School Counselor Suicide Prevention Training, Parents of Public Schools, University of Mississippi Medical Center Department of Psychiatry, Health Advisory Council, Pre-Evaluation Screening Training, Division of Consumer and Family Affairs,Youth and Family Affairs Legislative Committee, and faith-based organizations.

Presentations were made by the DMH Division of Children & Youth Staff at the following meetings/conferences/agencies: FASD Education and Training at the 139th Annual APHA Conference and for CMHCs, Hattiesburg's Zero to Three Program and MS Band of Choctaws, and non-profit providers; Mississippi's System of Care and Mental Health Services for MYPAC Providers and NFusion sites; Cultural Linguistic Competency

Trainings for NFusion sites, Child Welfare Conference; Children's Mental Health Resources at Disability Rights Mississippi; MS Mental Health Planning Council; Annual Lookin' To The Future Conference; Annual FASD Symposium; Introduction to Wraparound for CMHC clinicians; DMH Standards Training for TFC and TGH Providers; MAP Team 101 for new MAP Team Coordinators; Suicide Prevention/Intervention trainings were conducted to local non-profit agencies, middle and high school staff and administrators, university staff and administrators, mental health providers, youth detention center staff, and faith-based organizations, MS Families As Allies and two MS Transitional OutreachProject Sites; and the Youth and Family Affairs Legislative Committee.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to make available current information about children's mental health services through printed material and education by DMH staff.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to make available current information about children's mental health services through printed material and education by DMH staff.

Description of Collecting and Measuring Changes in Performance Indicator: Educational material dissemination documented on monthly staffing forms

***Footnote:** The Children and Youth Services Directory is available through the DMH agency website. CYS resource directories are also disseminated at conferences or meetings or to individuals.

Goal 3: To address suicide awareness, prevention and intervention through training sessions or workshops focused on this topic

Strategy: The DMH staff will conduct training or workshops upon request by mental health centers, universities, community colleges and other community agencies.

Performance Indicator: The number of trainings provided (four)

Baseline Measurement: In FY 2012, nine suicide prevention /intervention were conducted to local non-profit agencies, middle and high school staff and administrators, university staff and administrators, mental health providers, youth detention center staff, and faith-based organizations, MS Families As Allies and two MS Transitional Outreach Project Sites. Two Division of Children and Youth staff continue to maintain their certification as ASIST Trainers.

First-Year Target/Outcome Measurement: In FY 2014, two suicide awareness, prevention, and intervention trainings will be provided.

Second-Year Target/Outcome Measurement: In FY 2015, two suicide awareness, prevention, and intervention trainings will be provided.

Description of Collecting and Measuring Changes in Performance Indicator: Monthly Activity Reports Forms

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Goal 4: To co-sponsor statewide conferences and/or trainings on the System of Care for providers of mental health services, education services, rehabilitation, human services (child welfare), youth/juvenile justice, physical primary health, and families

Strategy: The DMH Division of Children and Youth will continue to provide support to statewide conferences and/or trainings for children's mental health service providers addressing system of care issues for participants from local and state child/family service agencies and families of children/youth with SED.

Performance Indicator: The number of statewide conferences and/or trainings sponsored or co-sponsored by the Division of Children & Youth Services (six)

Baseline Measurement: In FY 2012, the DMH continued to serve as a primary sponsor of the Annual Lookin' to the Future Conference conducted by Southern Christian Services. DMH also sponsored three Wraparound trainings held by the University of Maryland; an Applied Suicide Intervention Skills Training (A.S.I.S.T.); and the Annual FASD Symposium in September 2012. The Mississippi Transitional Outreach Project (MTOP) co-sponsored two (2) trainings focusing on effective services and supports for children and youth who are lesbian, gay, bisexual, transgender, questioning, intersex, two –spirit (LGBTQI2-S) and their families during FY 2012.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will sponsor or co-sponsor three statewide conferences on the System of Care.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will sponsor or co-sponsor three statewide conferences on the System of Care.

Description of Collecting and Measuring Changes in Performance Indicator: Registration Forms for the Conferences; Final Conference Reports

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Goal 5: To expand evidenced-based skills training in trauma-informed services for children/youth with emotional disturbances

Strategy: The DMH will continue to provide funds for the ongoing training in the evidence- based practice of trauma-focused cognitive behavior therapy.

Performance Indicator: The number of community mental health services staff who receive training in trauma-focused cognitive behavioral therapy and/or Trauma-Informed Care, SPARCS or other EPBs through Learning Collaboratives (90)

Baseline Measurement: In FY 2012, the Trauma Recovery for Youth Project (TRY) at Catholic Charities, Inc. of Jackson, MS trained clinicians in CMHC Regions 4,5,6,7,10, 11, and 12 in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TRY trained 116 clinicians in TF-CBT in seven CMHC Regions from July 1, 2011 through July 30, 2012.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will provide funding to expand evidence-based skills training in trauma-informed services for children/youth with serious emotional disturbances.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will provide funding to expand evidence-based skills training in trauma-informed services for children/youth with serious emotional disturbances.

Description of Collecting and Measuring Changes in Performance Indicator: Annual information collected from TRY staff at Catholic Charities, Inc. training agendas and sign-in sheets

***Footnote:** The Director of the DMH Division of Children and Youth Services served in an advisory role to the Mississippi Trauma Recovery for Youth (TRY) project, funded through SAMHSA. Catholic Charities, Inc. has led this four-year project. The conceptual framework of the project involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practice, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. The project also involves tracking of provision of services and treatment outcomes over a period of time.

Goal 6: To implement the Wraparound Model in 7 of the 15 Community Mental Health Centers.

Strategy: The DMH will continue to provide funds for training of additional CMHC staff for the 3-day Wraparound 101 course, a one-day Advanced Wraparound course and a 12-18 month process for Coach/Supervisor Training utilizing staff from the University of Maryland's Innovations Institute. The Division of Children and Youth Services partners with the Division of Medicaid, MYPAC Program to provide state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers.

Performance Indicator: The number of community mental health centers participating in the Coach/Supervisor training and implementing the Wraparound model (7 CMHCs)

Baseline Measurement: In FY 2012, CMHC Regions 4,6,7,9,10,12,and 15 are participating in the Coach/Supervision training for Wraparound Facilitation and are seeking DMH certification in Wraparound Facilitation.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to provide funding to implement the Wraparound Model in 7 of the 15 Community Mental Health Centers.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to provide funding to implement the Wraparound Model in 7 of the 15 Community Mental Health Centers.

Description of Collecting and Measuring Changes in Performance Indicator:
Quarterly and mid-year information collected from CMHCs including sign-in sheets for trainings.

***Footnote:** The Division of Medicaid planned to include Wraparound Facilitation in their submission to amend the State Medicaid Plan in FY 2012.

Goal 7: To expand specialized programs/resources for transition – aged youth, 14-21 years of age who are transitioning from child mental health services to adult mental health services and/or from an institutional setting into the community

Strategy: The Division of Children and Youth Services received a state-wide Children's Mental Health Initiative (System of Care) grant on October 1, 2009 to serve transition-aged youth with SED. This initiative, the Mississippi Transitional Outreach Program (MTOP), is implemented in three community mental health centers.

Performance Indicator: The number of MTOP local project sites that will develop and provide specialized services/resources for youth and young adults, 14-21 years (three)

Baseline Measurement: Two MTOP sites, one in Region 4 and one in Region 7, began providing services during FY 2011. An additional MTOP site in Region 4 (Desoto County) and a site in Region 10 received funding on October 1, 2011, and began providing services February 11, 2012. The funding for the Desoto County Program in Region 4 was retracted due to the recent acquisition of Desoto County into the Region 4 catchment area from Region 2. All parties involved agreed that Region 4's efforts should be soley focused on building a solid mental health infrastructure in Desoto County. Currently, there are three MTOP project sites operating.

First-Year Target/Outcome Measurement: In FY 2014, the three MTOP local project sites will continue to expand specialized programs/resources for transition-aged youth, ages 14-21, who are transitioning from children's mental health services to adult mental health services and/or from an institutional setting into the community.

Second-Year Target/Outcome Measurement: In FY 2015, the three MTOP local project sites will continue to expand specialized programs/resources for transition-aged youth, ages 14-21, who are transitioning from children's mental health services to adult mental health services and/or from an institutional setting into the community.

Description of Collecting and Measuring Changes in Performance Indicator: DMH monthly program reports, national program and evaluation reports

State Priority 4: 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 Division of Alcohol and Drug Abuse have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. 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 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 Task Force includes representatives from a local mental health center that provides a transitional living program, as well as representatives from the MS Department of Rehabilitation Services, the Office of the Attorney General and the DMH Divisions of Children and Youth Services and Alcohol and Drug Abuse. The Task Force 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 group has been able to identify ways to address the needs of the transition-age youth in an intensive case management model that utilizes the wraparound approach. Potential goals discussed included development of a resource/service directory to assist parents and professionals involved with this age group and strategies for increasing collaboration specifically targeting the transition age group. The work of this Task Force and its members assisted in the development of a successful grant application for a Children's Mental Health Initiative targeting transition – aged youth. The six-year System of Care grant provides funds for the implementation of three additional Transitional Outreach Programs (MTOP) across the state.

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 four (4) of the six (6) DMH certified transitional therapeutic group homes (Rowland, Harden House, and two programs operated by Hope Village).

Goal 1: To reduce involvement of youth with serious emotional disturbances in the juvenile justice system

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

Performance Indicator: Availability of technical assistance to Adolescent Offender Programs

Baseline Measurement: In FY 2012, DMH made two (2) visits to Adolescent Offender Programs in Regions 2 and 4 for certification/technical assistance.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by the DMH.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by the DMH.

Description of Collecting and Measuring Changes in Performance Indicator: Certification reports and Division of Children & Youth Services Monthly activity log (for technical assistance)

Footnote: From a system perspective, the Uniform Reporting System (URS) data (based on results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system, funded and certified by DMH, on the percentage of parents/caregivers of children/adolescents served by the public community mental health system reporting that their child had been arrested in one year, but was not rearrested in the next year) will also be reviewed**.**

Goal 2: To continue funding for mental health services for youth in two transitional therapeutic group home**s** and two supported living programs for youth in the transition age group (16-21 years of age).

Strategy: The DMH will continue funding two transitional living services group home**s** and two supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.

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

Baseline Measurement: In FY 2012, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and Hope Village (two programs); four of the homes received DMH funding support.

First-Year Target/Outcome Measurement: In FY 2014, DMH will continue funding for mental health services for youth in two transitional therapeutic group homes and two supported living programs for youth in the transition age group (16-21 years of age).

Second-Year Target/Outcome Measurement: In FY 2015, DMH will continue funding for mental health services for youth in two transitional therapeutic group homes and two supported living programs for youth in the transition age group (16-21 years of age).

Description of Collecting and Measuring Changes in Performance Indicator: Grant awards to continue funding to the targeted transitional living services/supported living programs

***Footnote:** The Transitional Services Task Force assisted in the development of a successful grant application for a Children's Mental Health Initiative targeting transition – aged youth. The six-year System of Care grant provides funds for the implementation of four additional Transitional Outreach Programs (TOP) across the state.

State Priority 5: Recovery Supports (Combined – SMHA/SSA)

The DMH Strategic Plan sets forth 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 2 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 2 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.

Youth Education/Support Initiatives

The Mississippi Families as Allies for Children's Mental Health, Inc. (MS FAA) supports two Youth Leadership Teams, one located in Jackson called the "Youth Making a Difference" team, which has 20 members and meets monthly during the school year. Meeting topics include conflict resolution, communication skills, alcohol and drug abuse prevention and other skills building activities. MS FAA also coordinates another Youth Leadership Team in the Hattiesburg area of the state, the site of Mississippi's second System of Care (SOC) initiative, commUNITY cares, which ended in September 2012. Although the initiative ended, MS FAA is continuing to work with the youth and families in that area to identify potential partners and sources of funding to continue the work the youth began. The SOC group also formed a Youth Advisory Council (YAC) to give input to the commUNITY cares project. Members of both youth groups have attended national SOC grant meetings, the Georgetown Training Institutes and FFCMH annual conferences; they have also made presentations at major state conferences and university social work classes. The youth in Hattiesburg produced an anti-stigma video this past Spring, which they presented to several audiences including the participants at a statewide Cultural and Linguistic Conference.

MS Families as Allies for Children's Mental Health, Inc. (MS FAA) conducts the Youth Summer Day Camp attended by 15-20 youth with emotional/behavioral challenges who generally experience problems participating successfully in other community day programs. The Youth Summer Camp also welcomes transition-age teens, who may be excluded from other types of camps. The camp gives the teens involved a sense of hope and competency. Based on the Youth Camp experiences thus far, youth have increased their ability to cope with daily challenges at school and in the community and to develop job readiness and independent living skills. Division of Children/Youth staff will continue to support and participate in special projects and activities of MS FAA.

The DMH also supports and provides funds to a youth-led non-profit organization, Youth Driven, Inc. Youth Engagement specialists are at all three local MTOP sites. The youth

specialists have developed local youth advisory boards and have become Youth MOVE chapters. The Statewide Youth Engagement Specialist and the local specialists developed a Statewide Youth Leadership Board who will meet on a regular basis to include retreats twice a year.

Goal 1: To continue to make available funding for family education and family support capabilities

Strategy: Continuation of funding for family education and family support will be made available by DMH for three DMH certified providers.

Performance Indicator: Number of family workshops and training opportunities to be provided and/or sponsored by the three funded agencies (42)

Baseline Measurement: In FY 2012, DMH continued to make funding available for family education and family support. Mississippi Families As Allies for Children's Mental Health, Inc. made available 42 family education/support groups (Harrison, Hinds, Forrest, and Warren Counties) and provided 15 family workshops and training opportunities involving 225 participants. NAMI-MS provided 8 NAMI Basics (Parent to Parent) classes with 58 participants and 12 Parent Support Meetings with 80 participants. Additionally, Region 10 was funded for parenting education classes for the parents of children with SED involved in the juvenile detention center and alternative school. The parent education course met 47 times weekly and has served 51 families.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to make available funding for family education and family support provided by three funded agencies.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to make available funding for family education and family support provided by three funded agencies.

Description of Collecting and Measuring Changes in Performance Indicator: Grant awards/monthly cash requests from MS Families As Allies for Children's Mental Health, Inc., MS NAMI, and Region 10 CMHC

Goal 2: To develop youth support and leadership teams in the current three project sites for the Mississippi Transitional Outreach Program (MTOP).

Strategy: The DMH will continue to support and fund the development of youth support and leadership teams in CMHC Regions 4 7, and 10.

Performance Indicator: Sign-in sheets of the meetings will be available during the year for CMHC Regions 4, 7, and 10.

Baseline Measurement: In FY 2012, Region 7 CMHC (NFusion VII) had 12 Youth Support Meetings and youth participated in 10 Governance Council Meetings. Region 4 CMHC (NFusion V) had 15 Youth Support Meetings and youth participated in 4 Governance Council Meetings as well as a youth retreat.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to develop youth support and leadership teams in the current three project sites for the Mississippi Transitional Outreach Project.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to develop youth support and leadership teams in the current three project sites for the Mississippi Transitional Outreach Project.

Description of Collecting and Measuring Changes in Performance Indicator: The sign-in sheets are provided by the local project coordinators

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Goal 3: To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health and substance abuse services

Strategy: The DMH will continue to refine the peer review/quality assurance process for all community mental health programs and services, including substance abuse services, by utilizing the Personal Outcome Measures (POM) interview protocol to measure outcomes of individuals receiving services.

Performance Indicator: Improved access and outcomes of services to individuals receiving services will be reported; number of peer review/site visits will be reported

Baseline Measurement: In FY 2012, there were 11 to 32 interviews conducted during 9 POM visits.

First-Year Target/Outcome Measurement: In FY 2014, a minimum of 9 POM visits will be conducted.

Second-Year Target/Outcome Measurement: In FY 2015, a minimum of 9 POM visits will be conducted.

Description of Collecting and Measuring Changes in Performance Indicator: POM tracking forms, report summaries

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Goal 4: To promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services

Strategy: Increase staff, consumers and their families understanding of topics related to recovery/recovery supports; the DMH Bureaus/Divisions will partner to plan resource/health fairs to educate others about recovery; information about the Mississippi Leadership Academy (MLA) will be made available to consumers with serious mental illness to increase communication and leadership/advocacy skills; continued funding will be made available by DMH for family education and family support programs/activities (e.g., drop-in centers, NAMI, MLA); and DMH will promote consumer information sharing and exchange through the MS Mental Health Recovery Social Network website.

Performance Indicator: Number of family education groups and number of family workshops and training opportunities to be provided will be tracked.

Baseline Measurement: In FY 2012, the following trainings were provided: three family to family, one peer to peer and four conferences focusing on recovery and peer support. Quarterly meetings with the Certified Peer Specialists providing education on meaningful participation and recovery were conducted.

First-Year Target/Outcome Measurement: In FY 2014, the number of family education groups, workshops and training opportunities will be increased.

Second-Year Target/Outcome Measurement: In FY 2015, the number of family education groups, workshops and training opportunities will be increased.

Description of Collecting and Measuring Changes in Performance Indicator:
Grant awards/monthly cash requests from service providers will be tracked; documentation/dates of material provided

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Goal 5: To establish policies and procedures to ensure consumer and family participation in monitoring/evaluating the mental health system through the peer review process

Strategy: The DMH Bureaus and Divisions will develop policies and procedures for the peer review process.

Performance Indicator: The DMH Bureaus and Divisions will develop policies and procedures for the peer review process.

Baseline Measurement: In FY 2012, the DMH developed policies and protocols using personal outcome measures (POM) to ensure consumer and family participation in the peer review process.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to utilize consumers, family members, and professionals in the POM process. Using the POMs and Components of Recovery, the DMH will evaluate the improvement of people's lives in their home, health and community.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to utilize consumers, family members, and professionals in the POM process. Using the POMs and Components of Recovery, the DMH will evaluate the improvement of people's lives in their home, health and community.

Description of Collecting and Measuring Changes in Performance Indicator:
The DMH will utilize the Council on Quality and Leadership's (CQL) Personal Outcome Measures (POM) tool to gain information about the level at which service providers are supporting personal outcomes of individuals being served. Policies and procedures and number of POM interviews conducted by consumers and family members will be tracked

Priority 6: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined – MHA/SSA)

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 continue to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance abuse problems which also address problems of youth with co-occurring disorders. Staff in both the DMH Bureau of Alcohol and Drug Services and the Division of Children and Youth Services has provided training, information and support to women who may be pregnant or may have children with them while receiving treatment in one of the adult substance abuse residential treatment programs. A registered nurse at a primary residential Alcohol and Drug treatment facility has been trained and educated by DMH staff to discuss the dangers of drinking while pregnant with the women who are receiving services.

The Division of Children and Youth Services designates–a Fetal Alcohol Spectrum Disorder (FASD) State Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS-AC-FASD) and co-sponsors an annual FASD Symposium for professionals and families.

The Annual Mississippi School for Addiction Professionals and the annual Lookin' to the Future Conference provides sessions on youth with co-occurring disorders.

The DMH continues to provide funding to two community based residential treatment programs, which make available chemical dependence residential treatment for adolescents, some of whom also have a serious emotional disturbance.

The Bureau of Alcohol and Drug Services and the Bureau of Community Services have an ongoing collaboration to continue to provide treatment services for adults with both mental illness and substance abuse disorders, participate in joint education and training initiatives and conduct monitoring of programs throughout the state.

Goal 1 also addresses State Priority Area 3: Expansion of System of Care for Children and Youth with SED

Goal 1: The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned.

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

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

Baseline Measurement: In FY 2012, Dr. Peter Gamache from the Turnaround Achievement Network provided a workshop entitled *"Substance Abuse & Sexual Minorities-LGBTQI2-S"* at the 5th Annual Mississippi School for Addiction Professionals held in Hattiesburg, Mississippi, April 10-13, 2012. Other sessions specifically addressing children and youth with SED offered at the School include *"Adolescent Self-Mutilation and Suicide"* presented by Dr. Susan Eaves Carmichael, *"Alcohol and Drugs: Current Trends and Practices"* presented by Officer Jermaine Galloway, and *"Media, Our Culture, & Drug Use"* presented by Nigel Wrangham.

First-Year Target/Outcome Measurement: In FY 2014, the DMH Division of Children and Youth Services will include a workshop regarding issues of children/youth with SED and substance abuse/misuse problems in a statewide conference.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH Division of Children and Youth Services will include a workshop regarding issues of children/youth with SED and substance abuse/misuse problems in a statewide conference.

Description of Collecting and Measuring Changes in Performance Indicator: Conference program(s)

Goal 2: To provide funding to maintain community-based residential treatment services for adolescents with substance abuse problems and co-occurring disorders

Strategy: The Division of Children and Youth services will provide funding to two community-based residential treatment program services and beds for adolescents with substance abuse problems and co-occurring disorders. Services provided include individual counseling, psychotherapeutic group counseling, self-help groups, family counseling, education services dealing with substance abuse and addiction, educational programs at the appropriate academic levels, vocational counseling services, and recreational and social activities.

Performance Indicator: Number of youth served in community-based residential treatment programs for adolescents with substance abuse problems that receive funds from the DMH

Baseline Measurement: In FY 2012, two programs served 107 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in community-based residential treatment. Sunflower Landing served 68 youth (44 of whom had co-occurring disorders) and the ARK served 39 youth (32 of whom had co-occurring disorders).

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to provide funding to maintain community-based residential treatment services for adolescents with substance misuse/abuse problems and co-occurring disorders.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to provide funding to maintain community-based residential treatment services for adolescents with substance misuse/abuse problems and co-occurring disorders.

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Services Residential Monthly Summary Form/Grant Proposals for two community-based residential treatment sites.

Goal 3: To further develop the linkage between the Bureau of Alcohol and Drug Services and the Bureau of Community Services regarding COD's in individuals with SED, FASD, SMI and Substance Abuse

Strategy: Both Bureaus will collaborate in a state-wide conference planned for FY 2013 **(**MS School for Addiction Professionals), and both Bureaus will continue to monitor and provide technical assistance to co-occurring programs upon request.

Baseline Measurement: In FY 2012, the 5th Annual Mississippi School for Addiction Professionals was held at the Lake Terrace Convention Center in Hattiesburg, Mississippi. The Bureau of Community Services sponsored workshops for the conference addressing co-occurring disorders in youth.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to provide technical assistance visits as requested to programs implementing services for individuals with co-occurring disorders. Collaboration between the two Bureaus to provide a statewide conference on co-occurring disorders will also continue.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to provide technical assistance visits as requested to programs implementing services for individuals with co-occurring disorders. Collaboration between the two Bureaus to provide a statewide conference on co-occurring disorders will also continue.

Performance Indicator: Number of technical assistance and certification visits by the DMH staff to programs implementing and/or planning programs to serve individuals with co-occurring disorders will be tracked; conference planning minutes and conference agenda; and Division of Children and Youth Monthly Reporting Form to track technical assistance provided

Description of Collecting and Measuring Changes in Performance Indicator: Conference program, sign in sheets, agendas, and program monitoring schedules

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Goal 4: To continue to provide community-based residential treatment services to individuals with co-occurring disorders

Strategy: Continued operation of a residential treatment service for individuals with co-occurring disorders with serious mental illness and substance abuse. Funds will be provided to continue support for operation of a 12-bed community-based residential facility for individuals with a co-occurring disorder operated by the Division of Community Services of Mississippi State Hospital.

Performance Indicator: The number of community residential treatment beds to be made available (12 beds)

Baseline Measurement: In FY 2012, twelve community residential treatment beds were made available.

First-Year Target/Outcome Measurement: In FY 2014, twelve community residential treatment beds will be made available.

Second-Year Target/Outcome Measurement: In FY 2015, twelve community residential treatment beds will be made available.

Description of Collecting and Measuring Changes in Performance Indicator: MS State Hospital is required to submit monthly data on the number of occupied/unoccupied beds. Yearly RFPs (request for proposal) and monthly cash requests are submitted to the DMH.

Goal 5: To continue to provide community services to individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital

Strategy: The DMH will continue to provide community services to individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

Performance Indicator: All 15 CMHCs and the Community Services Division of Mississippi State Hospital will provide services to individuals with co-occurring disorders.

Baseline Measurement: In FY 2012, 11,123 individuals in the 15 CMHCs and the Community Services Division of MSH received services for COD.

First-Year Target/Outcome Measurement: In FY 2014, a minimum of 10,500 individuals will receive services for COD.

Second-Year Target/Outcome Measurement: In FY 2015, a minimum of 10, 500 individuals will receive services for COD.

Description of Collecting and Measuring Changes in Performance Indicator: Data is collected utilizing the annual state plan surveys submitted from the 15 CMHCs and MSH.

Priority 7: Integration of Behavioral Health and Primary Care Services (Combined – SMHA/SSA)

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. 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 Drug Abuse reflect the elements in the Department of Mental Health's Ten-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 abuse are included 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). The DMH intends to build on a collaborative initiative with the Mississippi Primary Health Care Association (MPHCA), the Division of Medicaid, and the community mental health centers. The Department of Mental Health and Mississippi Primary Healthcare Association have been involved in preliminary discussions regarding re-establishing a structured collaborative effort and inviting partner agencies, such as the Division of Medicaid, the Mississippi State Department of Health, the Department of Human Services and the University Medical Center, to promote communication among specialty system providers and primary care providers. Collaborative efforts include 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**.** Dr. Lydia Weisser, the DMH Medical Director, serves as the DMH "content expert" on primary care and behavioral health integration.

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

- A representative from 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 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 Abuse 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 abuse 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 continues to fund prevention services with Choctaw Behavioral Health.
- The DMH funds Region 4 and Region 8 CMHCs to provide therapeutic nursing services in the schools, which include services such as providing education for children/youth with SED, their families and teachers, conducting physical observations and assessments**,** providing information about and monitoring medications, monitoring sleeping and eating habits, and assisting with health objectives on treatment plans, etc.
- The DMH Bureau of Alcohol and Drug Abuse has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. The DMH BADA partnership includes trainings around the state. The training is also available for A&D personnel located at community mental health centers.

Goal 1: To provide support for registered nurses to address physical/medical needs of children with SED in one rural, one mixed rural/urban area of the state

Strategy: Continue to fund targeted community mental health regions to provide ongoing therapeutic nursing services to children with SED, which include providing education for children/youth with SED, their families and teachers, conducting physical observations and assessments, providing information about and monitoring medications, monitoring sleeping and eating habits, and assisting with health objectives on treatment plans, etc. Designated Division of Children and Youth staff will continue to provide technical assistance to the CMHC providing these nursing services and monitors the delivery of such services in accordance with requirements of the RFP.

Performance Indicator: The number of regions to which the DMH will provide funding or intensive therapeutic nursing services for children with serious emotional disturbances (two)

Baseline Measurement: In FY 2012, 3,791 children and youth received intensive therapeutic nursing services.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will provide support for registered nurses to address physical/medical needs of children with SED in one rural, one mixed rural/urban area of the state.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will provide support for registered nurses to address physical/medical needs of children with SED in one rural, one mixed rural/urban area of the state.

Description of Collecting and Measuring Changes in Performance Indicator: Therapeutic nursing monthly summary form

Goal 2: Improve the coordination of services for all individuals across primary care and mental health systems through co-integration and collaboration with and among the DMH Bureaus and Divisions, Primary Healthcare Providers (PHPs), consumers, family members, and other interested stakeholders

Strategy: The DMH Bureaus and Divisions will continue to develop and maintain partnerships with PHPs through a collaborative effort including, but not limited to, Making A Plan Teams (MAP), Community Support Services, Substance Abuse Coordinators, Peer Specialists, and the DMH Integration Work Group. The DMH will open dialog with PHPs regarding how specific functions and services can be enhanced, blended, streamlined between Community Mental Health Centers (CMHCs) and PHPs. The DMH will increase partnership activities between local entities and community providers such as hospitals, holding facilities, Crisis Stabilization Units, and CMHCs to establish triage, treatment, and diversion plans and to develop a plan for integrating mental illness, addiction, and Intellectual and Developmental Disabilities (IDD) services with primary health care.

Performance Indicator: List of PHPs in Mississippi for dissemination; Number of modifications in provider policies and procedures; monthly service reports; meeting minutes and attendance sheets; explore and expand evidence-based practice (EBP) models related to successful integration; documentation of collaboration via grant planning meetings to acquire funding; receipt of funding opportunities awarded to promote integration; development of a plan to integrate behavioral health and primary care services; number of MOUs developed with PHPs

Baseline Measurement: New goal. No baseline data is available.

First-Year Target/Outcome Measurement: In FY 2014, the DMH will continue to improve the coordination of services for all individuals across primary care and mental health systems through co-integration and collaboration with and among the DMH Bureaus and Divisions, Primary Healthcare Providers (PHPs), consumers, family members, and other interested stakeholders

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will continue to improve the coordination of services for all individuals across primary care and mental health systems through co-integration and collaboration with and among the DMH Bureaus and Divisions, Primary Healthcare Providers (PHPs), consumers, family members, and other interested stakeholders

Description of Collecting and Measuring Changes in Performance Indicator: A record of dialog with PHPs will be established and maintained and documentation of outreach efforts and process for development of plan for integrating behavioral health and primary care services will be maintained.

Goal 3: FASD screening assessments will be made available in all 15 CMHC regions across the state, including MAP Teams, to determine the need for a diagnostic evaluation in children/youth (birth-18 years of age).

Strategy: The DMH Operational Standards require children ages birth to age eighteen (18) be screened within six (6) months of Intake to determine the need for a FASD diagnostic evaluation for identification of primary health and behavioral health problems, and for intervention and treatment by behavioral and primary care providers in the local

community. Local MAP Team Coordinators will coordinate the FASD screenings, referring children for diagnosis, and coordinating the provision of services. Case Managers at CMHCs implement interventions identified and assist in accessing needed primary care and behavioral health services.

Performance Indicator: Increased number of FASD screenings conducted by the CMHC and/or MAP Team (5,000); increased number of FASD diagnoses will be reported

Baseline Measurement: In FY 2012, CMHCs screened 7,727 children ages birth to eighteen to identify those children who needed to be referred to the Child Development Center at the University of Mississippi Medical Center for a full FASD diagnostic evaluation. During FY 2012, 412 children and youth were screened positive for FASD.

First-Year Target/Outcome Measure: In FY 2014, FASD screening assessments will be made available in all 15 CMHC regions across the state, including MAP Teams. At least 2,500 children/youth birth to 18 years of age will be screened for a FASD.

Second-Year Target/Outcome Measure: In FY 2015, FASD screening assessments will be made available in all 15 CMHC regions across the state, including MAP Teams. At least 2,500 children/youth birth to 18 years of age will be screened for a FASD.

Description of Collecting and Measuring Changes in Performance Indicator: The number of FASD screenings conducted each year in or through the CMHCs and MAP Teams are counted on DMH Division of Children and Youth Monthly Service Report forms and MAP Team Referral reports and entered into a database at the DMH Division of Children and Youth

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Goal 4: To increase access to community-based, co-integrated, holistic care and supports through a network of service providers committed to be resiliency and recovery-oriented system of care

Strategy: The DMH Bureaus and Divisions will promote interagency and multidisciplinary collaboration and partnerships by participating in meetings and actions of the Integration Work Group (IWG). Through the IWG, the DMH will develop strategies and increase partnerships to facilitate integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care to encompass a holistic care approach to service provision. The IWG developed an informal baseline document from which to measure growth in knowledge of and in provision of co-integrated services. Annually, additional information on primary and behavioral health care integration will be gathered by survey by the DMH Bureau of Community Services. The DMH will also continue to seek and develop possible funding opportunities for integrated care

Performance Indicator: Attendance records at IWG meetings, updated information in Annual Community Services Survey concerning integrated primary and behavioral health care services, documentation of collaboration on grant application, multidisciplinary collaboration and participation, baseline information from community-based programs concerning integrated primary and behavioral healthcare, documentation of collaborative meetings on grant opportunities

Baseline Measurement: In FY 2012, the IWG met four times.

First-Year Target/Outcome Measurement: In FY 2014, the IWG will meet a minimum of 4 times showing interagency and multidisciplinary collaboration participation. The Annual Community Services Survey will be conducted. Grant application(s) will be submitted if opportunities are available.

Second-Year Target/Outcome Measurement: In FY 2015, the IWG will meet a minimum of 4 times showing interagency and multidisciplinary collaboration participation. The Annual Community Services Survey will be conducted. Grant application(s) will be submitted if opportunities are available.

Description of Collecting and Measuring Changes in Performance Indicator:
Attendance records and documentation, FY 2012 baseline data, Annual Community Services Surveys are conducted at the end of each calendar year to collect information from the previous fiscal year. This updated information will be added to the baseline document each year and will be used by the IWG to assist in developing strategies for the next year. Documentation of grant activities are maintained, including meting notes and grant applications

Priority 8: Trauma (Combined - SMHA/SSA)

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 life 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. Mississippi has two National Child Traumatic Stress Network Sites, Catholic Charities, Inc. and Region 13/Gulf Coast Mental Health Center.

Goal 1: To educate and train community leaders on Mental Health First Aid

Strategy: The DMH staff will train pastors, teachers, civic groups and families and friends on Mental Health First Aid.

Performance Indicator: Number of trainings by DMH staff, agenda, sign in sheets

Baseline Measurement: New Goal. No baseline data available

First-Year Target/Outcome Measurement: In FY 2014, the DMH will educate and train community leaders on Mental Health First Aid.

Second-Year Target/Outcome Measurement: In FY 2015, the DMH will educate and train community leaders on Mental Health First Aid.

Description of Collecting and Measuring Changes in Performance Indicator: Number of trainings, sign in sheets, agendas

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Goal 2: To provide an array of trainings on trauma throughout the state

Strategy: The Division of Children and Youth will provide training utilizing the Child Welfare Trauma Toolkit-Revised to agencies and community partners that are a part of the MS system of care.

Strategy: The Bureau of Alcohol and Drug Services will provide three trauma sessions at the Mississippi School for Addiction Professional in April, 2013. They will focus on Trauma Informed care, Trauma Focused Cognitive Behavioral Therapy (TFCBT), and Recovery.

Performance Indicator: Number of trainings by DMH staff, agenda, sign in sheets

Baseline Measurement: New Goal. No baseline data available

First-Year Target/Outcome Measurement: In 2014, the DMH will provide an array of trainings on trauma throughout the state.

Second-Year Target/Outcome Measurement: In 2015, the DMH will provide an array of trainings on trauma throughout the state.

Description of Collecting and Measuring Changes in Performance Indicator: Number of trainings, sign in sheets, agendas

Priority 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

An adult with a serious mental illness is defined as any individual, age 18 or older, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills.

The majority of the public community mental health services for adults with serious mental illness in Mississippi is provided through 15 regional mental health/mental retardation commissions, which operate 15 regional community mental health centers serving all 82 counties of the state. The mental health centers are governed by regional commissions, with representative commissioners for each county in the region appointed by county Boards of Supervisors. The Mississippi Department of Mental Health sets and monitors implementation of operational standards for community mental health programs certified through the authority of the DMH. Implementation of these standards, which establish minimum requirements for programs in organization and management in specific services, is monitored through on-site visits of programs throughout the year by DMH staff. Community services (e.g., psychosocial rehabilitation services, supervised housing, crisis services, and specialized programs for homeless persons with mental illness) are also provided to individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These programs are also monitored for compliance of the operational standards applicable to the community mental health programs they provide. Community Mental Health Centers provide pre-evaluation screening for individuals referred for evaluation for commitment to the state inpatient programs**,** which provide regionalized, inpatient services.

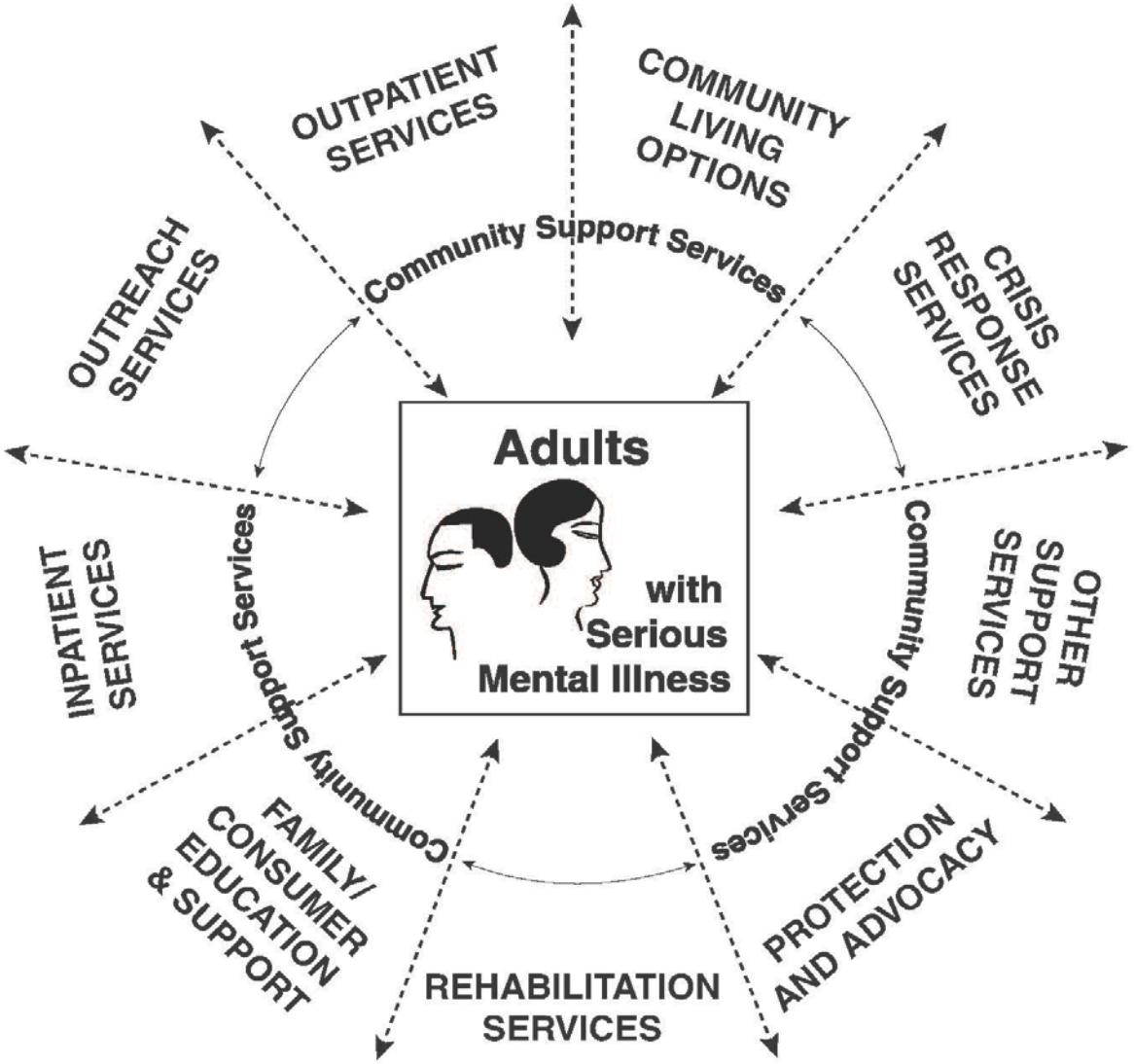
Ideal System Model

The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness was developed to reflect an ideal system that is responsive to the strengths and needs of all individuals with serious mental illness. At the center of the system is the person, each with his or her individual strengths and needs, which vary across time and circumstances. Community Support Services revolve around the person, between the person and his or her family, and components of the mental health and support system. Community Support Services is the key to accessing and coordinating mental health and support services needed by the individual. In the ideal system, the case manager continually works with the individual to aid in identifying goals, recognizing strengths and barriers, and -developing and implementing an action plan based on identified needs. The Ideal System Model for Adults emphasizes a psychosocial rehabilitation approach in making an array of appropriate mental health, social, vocational, educational, and other support options available based on individuals' strengths and needs. Several types of service options and activities may be included in the service components. A major change in the description of the characteristics of the system has been made to reflect a philosophy shift to one that is more 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 major service components of the Ideal System Model for Adults include: consumer support services**,** outpatient services, crisis response services, community living options**,** identification and outreach, psychosocial rehabilitation services, family/consumer education and support, inpatient services, protection and advocacy, and other support

services. Services for individuals with a co-occurring disorder of serious mental illness and substance abuse are also included in the system of community-based care.

IDEAL SYSTEM MODEL

Mississippi Comprehensive Community Mental Health System
for
Adults With Serious Mental Illness



CHARACTERISTICS OF THE SYSTEM

- ❑ Person - Directed
- ❑ System Access and Coordination Through Community Support Services
- ❑ Arrows Represent Easy Transition In, Across, and Out of Service
- ❑ Emphasis on Recovery

Goal 1: To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health services

Strategy: The DMH will continue to refine the quality assurance process for all adult community mental health programs and services by incorporating the voice of individuals and /or family members in the planning, evaluation and implementation of services.

Performance Indicator: Improved access and outcomes of services to individuals receiving services will be reported. Number of consumers and family members involved in decision-making activities including: advisory councils, task forces and work groups on a state level will be increased. The involvement of individuals and/or family members in evaluating services through POM interviews will be increased.

Baseline Measurement: In FY 2012, there were approximately 10 individuals and/or family members participating in advisory councils, task forces and work groups at the state level. There were five individuals trained to conduct POM interviews. Twenty POM interviews were conducted. There were 97 individuals and/or family members trained as Certified Peer Support Specialists.

First-Year Target/Outcome Measurement: In 2014, the number of individuals and/or family members participating in advisory councils, task forces and work groups will be increased.

Second-Year Target/Outcome Measurement: In 2015, the number of individuals and/or family members participating in advisory councils, task forces and work groups will be increased.

Description of Collecting Changes in Performance Indicator: Work group reports, sign in sheets, minutes from meetings

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Goal 2: To make available funding to support an array of "Core" services to assist adults with serious mental illness.

Strategy: The DMH will continue to provide grants, support and technical assistance to community providers that offer an array of community mental health services and supports. These services include:

Outpatient Services, a component of the ideal system, includes diagnostic and treatment Services in various treatment modalities for persons requiring less intensive care than inpatient services including individuals with serious mental illness

Psychosocial Rehabilitative 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.

Day Support Services provide structured, varied and age appropriate clinical activities in a group setting that are designed to support and enhance the individual's independence in the community through the provision of structured supports.

Acute Partial Hospitalization is a psychosocial rehabilitative service that is designed to provide an alternative to inpatient hospitalization or to serve as a bridge from inpatient to outpatient treatment.

Supported Living includes an array of supports and services that are provided in an integrated community setting by a provider with appropriate staff and resources to assist an individual who needs assistance less than twenty-four (24) hours per day/seven (7) days per week.

Supervised Living includes an array of supports and services provided with appropriate staff and resources to support an individual who needs assistance twenty-four (24) hours per day/seven (7) days per week to live in the community.

Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists.

Psychiatric/Physician's Services are services of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance.

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy to individuals who are experiencing a period of acute psychiatric distress.

Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms and challenges associated with various disabilities while directing their own recovery.

Targeted Case Management Services provide information and resource coordination for individuals and collaterals. These services are directed toward helping individuals maintain the highest possible level of independent functioning.

Performance Indicator: The number of individuals served in the community will be tracked.

Baseline Measurement: In FY 2012, 77,550 individuals were served in the community.

First-Year Target/Outcome Measurement: In 2014, a minimum of 74,000 individuals will be served in the community.

Second-Year Target/Outcome Measurement: In 2015, a minimum of 74,000 individuals will be served in the community.

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of grant award on file at DMH; monthly cash requests, satisfaction surveys

***Footnote:** The DMH will continue efforts to expand access and availability of Housing options for individuals with serious mental illness, including acquiring sufficient staff time, training and resources to continue the development of service linkages with multiple housing partners at the state and regional levels and to identify support services and

funding to sustain individuals living in permanent supportive housing. Funding related to these efforts will be requested for FY 2014.

Goal 3: To provide resources and supports to allow adults with SMI to live in the community and reduce hospitalizations

Strategy: The DMH will continue to provide funding to the Crisis Stabilization Units throughout the state.

Performance Indicator: Decrease in the number of admissions to behavioral health programs.

Baseline Measurement: In FY 2012, 3,207 individuals were diverted from the behavioral health programs and admitted to the CSUs.

First-Year Target/Outcome Measurement: In 2014, 3,500 individuals will be diverted to the CSUs.

Second-Year Target/Outcome Measurement: In 2015, 3,500 individuals will be diverted to the CSUs

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of grant awards on file at the DMH; monthly cash requests, CSUs submit daily census reports monthly, CSUs submit monthly data report

***Footnote**: The Department of Mental Health remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Included in this array are services designed to divert hospitalization, and to address those factors determined to be associated most often with hospitalization or rehospitalization as well as to prevent inappropriate placement of individuals in jail.

Goal 4: To expand skills training to services providers in the provision of services for Adults with SMI

Strategy: The DMH will continue to provide training, support and technical assistance for staff working with adults with SMI, including the following programs:

- The Department of Mental Health Consumer Support Specialist is an internet-based staff training and development program. The Essential Learning training website tracks staff training. and eliminate**s** the need for extensive travel for case managers to obtain training.

- The DMH will continue to make available training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Operational Standards. Pre-evaluation Screening for Civil Commitment Services assists in reducing the number of inappropriate admissions to the behavioral health programs.

- The DMH will continue to made funding available to the 15 CMHCs to help support provision of law enforcement training.

Performance Indicator: The number of community mental health services staff who receive training

Baseline Measurement: In FY 2012, 81 staff who work with adults with SMI were enrolled in the Essential Learning training website, 85 staff who work with adults with SMI received training on the pre-evaluation screening civil commitment process and 38 staff who work with adults with SMI received training on law enforcement.

First-Year Target/Outcome Measurement: In 2014, a minimum of 60 staff who work with adults with SMI will receive training through the Essential Learning training website, a minimum of 60 staff who work with adults with SMI will receive training on the pre-evaluation screening civil commitment process and a minimum of 30 staff who work with adults with SMI, received training on law enforcement.

Second-Year Target/Outcome Measurement: In 2015, a minimum of 60 staff who work with adults with SMI will receive training through the Essential Learning training website, a minimum of 60 staff who work with adults with SMI will receive training on the pre-evaluation screening civil commitment process and a minimum of 30 staff who work with adults with SMI, received training on law enforcement.

Description of Collecting and Measuring Changes in Performance Indicator: The DMH Learning Management System, sign in sheets for the pre-evaluation trainings, law enforcement grants and cash requests submitted after law enforcement trainings

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Goal 5: To facilitate skills training for staff of senior psychosocial rehabilitation programs

Strategy: The DMH will continue to provide a one to two day training for staff in the senior psychosocial rehabilitation programs. There are currently three training sites that provide technical assistance.

Performance Indicator: The number of community mental health services staff who complete training for elderly psychosocial rehabilitation program

Baseline Measurement: In FY 2012, 12 mental health services staff completed the senior psychosocial rehabilitation training.

First-Year Target/Outcome Measurement: In 2014, a minimum of 8 mental health staff will complete the senior psychosocial rehabilitation training.

Second-Year Target/Outcome Measurement: In 2015, a minimum of 8 mental health staff will complete the senior psychosocial rehabilitation training.

Description of Collecting and Measuring Changes in Performance Indicator: The three senior psychosocial training sites submit yearly grant proposals, sign in sheets and cash requests after each training

Goal 6 also addresses State Priority Area 1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal 6: To address the stigma associated with mental illness through a mental illness campaign

Strategy: The DMH will continue to lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the anti-stigma campaign.

Performance Indicator: Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers (200,000). The DMH will also track the number of live interviews and presentations.

Baseline Measurement: In FY 2012, 55 presentations were conducted. More than 100,000 brochures have been distributed since 2008 and more than 10,000 potty posters have been distributed to schools across the state. Mississippi teachers are now required to participate in suicide prevention treatment.

First-Year Target/Outcome Measurement: In 2014, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.

Second-Year Target/Outcome Measurement: In 2015, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.

Description of Collecting and Measuring Changes in Performance Indicator: Media and educational presentation tracking data maintained by DMH Director of Public Information

***Footnote:** More than 100,000 brochures have been distributed since 2008. More than 10,000 Potty posters have been distributed to schools across the state. In 2010, 104 presentations were conducted with parents, teachers, and students. In 2011, 132 presentations were conducted. In 2012, 55 presentations were conducted. Mississippi teachers are now required to participate in suicide prevention treatment. Since 2010, more than 55,000 teachers, parents and students have been reached via presentations.

Goal 7 also addresses State Priority Area 1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal 7: To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force

Strategy: Continued meetings/activity by the Multicultural Task Force will be provided. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas.

Performance Indicator: The number of meetings of the Multicultural Task Force during FY 2012 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council

Baseline Measurement: In FY 2012, the Multicultural Task Force had three meetings.

First-Year Target/Outcome Measurement: In 2014, the Multicultural Task Force will have at least two meetings.

Second-Year Target/Outcome Measurement: In 2015, the Multicultural Task Force will have at least two meetings.

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made.

Goal 8: Explore the development of a Mental Health and Aging Coalitions

Strategy: Identify stakeholders including but not limited to the MS Department of Human Services Division of Aging and Adult Services, Community Mental Health Centers; continued participation in national organizations including the Older Persons Division of National Association of Substance Abuse and Mental Health Program Directors; identify potential resources

Performance Indicator: The number of interested stakeholders interested in the development of a Mental Health and Aging Coalition

Baseline Measurement: New Goal. No baseline data available.

First-Year Target/Outcome Measurement: In 2014, five interested stakeholders will be identified in participating in the development of a Mental Health and Aging Coalition.

Second-Year Target/Outcome Measurement: In 2015, five interested stakeholders will be identified in participating in the development of a Mental Health and Aging Coalition

Description of Collecting and Measuring Changes in Performance Indicator: Minutes from meetings, list of interested stakeholders

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Goal 9: Increase the number of Adult Day Programs for individuals with Alzheimer's Disease and/or related dementia

Strategy: Staff will research best practices for respite services; review models funded through alternative sources such as federal funding sources and foundational funding sources, and review other states' models for respite services. Progress will be reported to the Alzheimer's Planning Council.

Indicator: The number of adult day programs certified by the DMH.

Baseline Measurement: In FY 2012, the DMH certified two Alzheimer adult day programs.

First-Year Target/Outcome Measurement: In 2014, the DMH will certify four Alzheimer adult day programs.

Second-Year Target/Outcome Measurement: In 2015, the DMH will certify four Alzheimer adult day programs.

Description of Collecting and Measuring Changes in Performance Indicator:
Number of program certificates, summary of respite services review activities

State Priority 10: Targeted Services to Rural and Homeless Adults with SMI

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 or PATH) funds would have the greatest impact (Jackson, Meridian and the Gulf Coast).

The DMH staff continue to participate with Project CONNECT, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area. The DMH staff also continued to attend meetings of MISSIONLinks, which is an alliance of emergency and transitional shelter operators and mental health service providers. The DMH staff continue 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.

The DMH has received 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 who provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process. To date, six 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. The DMH is overseeing the data collection process as administered by the Mental Health Association of South Mississippi in the Gulf Coast counties that are part of the Open Doors Homeless Coalition.

Community mental health centers will continue to be required to develop plans for outreach, including transportation, as part of their community support services plans approved by the DMH. The Mississippi Transportation Coalition, which includes representation from the DMH, continues to meet monthly to address coordinated planning for transportation. In FY 2010, the DMH received Transformation Transfer Initiative (TTI) funding from the Center for Mental Health Services, one component of which will enhance the coordination of transportation services and service providers. The DMH will also utilize grant funds to pay for transportation for individuals with disabilities. In FY 2011, the DMH continued to work on a pilot project in the Region 6 CMHC catchment area. It is anticipated, that after 100 transportation needs assessments have been conducted, a local transportation provider will begin a call-in center. This call-in center will provide rides for individuals with disabilities at a reduced rate. It is our hope to replicate this pilot project statewide when funding is available.

Goal 1*:* To provide coordinated services for homeless persons with mental illness

Strategy: The DMH will continue to provide targeted services for homeless individuals with mental illness in targeted areas of the state.

Performance Indicator: The number of persons with serious mental illness served through specialized programs for homeless persons

Baseline Measurement: In FY 2012, 1024 persons with serious mental illness were served through specialized programs for homeless persons.

First-Year Target/Outcome Measurement: In 2014, a minimum of 950 persons with serious mental illness will be served through specialized programs for homeless persons.

Second-Year Target/Outcome Measurement: In 2015, a minimum of 950 persons with serious mental illness will be served through specialized programs for homeless persons.

Description of Collecting and Measuring Changes in Performance Indicator: Adult Services State Plan Survey; PATH Grant Annual Report

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Goal 2: To educate providers, consumers and other interested individuals/groups about the needs of homeless individuals, including the needs of homeless persons with mental illness

Strategy: A DMH staff member will continue to participate on interagency workgroups that identify and/or address the needs of individuals who are homeless. A DMH staff member continues to participate in the three Continua of Care in Mississippi (i.e., Open Doors, Mississippi United to End Homelessness, Partners to End Homelessness), as well as MISSIONLinks, Project Connect, the DMH Housing Task Force and the State Planning Council meetings. A DMH staff member has presented information to these groups on both the PATH Program and the State SOAR Initiative. A DMH staff person is the Team Leader for the Medicaid Balancing Incentives Program (BIP) Housing Team which is tasked with the responsibility of making recommendations to the Mississippi Division of Medicaid regarding ways to improve and expand housing options for individuals with serious mental illness and other special needs and disabilities.

Performance Indicator: The number of workgroups addressing homelessness on which DMH staff member(s) participate (up to three)

Baseline Measurement: In FY 2012, DMH staff participated in two workgroups addressing homelessness.

First-Year Target/Outcome Measurement: In 2014, DMH staff will attend a minimum of two workgroups addressing homelessness.

Second-Year Target/Outcome Measurement: In 2015, DMH staff will attend a minimum of two workgroups addressing homelessness.

Description of Collecting and Measuring Changes in Performance Indicator: Minutes of workgroup meetings and/or Division Activity Reports

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Goal 3: To make mental health services available to individuals in rural areas

Strategy: CMHCs are required to submit a plan addressing outreach and transportation services.

Performance Indicator: The number of CMHCs who have local plans that address transportation services

Baseline Measurement: In FY 2012, 15 CMHCs submitted local plans that addressed transportation.

First-Year Target/Outcome Measurement: In 2014, 15 CMHCs will submit local plans that address transportation.

Second-Year Target/Outcome Measurement: In 2015, 15 CMHCs will submit local plans that address transportation.

Description of Collecting and Measuring Changes in Performance Indicator: CMHC'**s** plan addressing transportation

State Priority 11: Management Systems

Management goals that assist in improving information management systems, continuing helpline services through the Office of Consumer Support Services and requesting additional funding for community mental health services to both child and adult service address this priority.

Goal 1: To develop a uniform, comprehensive, automated information management system for all programs administered and/or funded by the Department of Mental Health

Strategy:

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

- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent progress tracked through the CMHS MH DIG Quality Improvement project

- Periodic review and revision of the DMH Manual of Uniform Data standards

- Continued communication with and/or provision of technical support needed by the DMH Central Office programmatic staff who are developing performance/outcome measures

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

- Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs

- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the MH DIG Quality Improvement project

- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors

Performance Indicator: Established central data repository (CDR) with DMH certified providers submitting as required by the DMH

Description of Collecting and Measuring Changes in Performance Indicator: Meeting minutes and technical assistance worksheets

Goal 2: The Office of Consumer Support (OCS) is responsible for maintaining a toll-free line and providing assistance to individuals receiving services and their families. The OCS assists in resolving grievances related to access to services and service provision, providing education regarding the rights of individuals receiving services, and responding to general questions concerning services for individuals with serious mental illness, intellectual/development disabilities and substance use disorders.

Strategy: The nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software will be tracked.

Performance Indicator: The number and category of calls received through the helpline

Baseline Measurement: In FY 2012, the helpline received approximately 4,500 calls and responded to more than 75 grievances. The Office of Consumer Support assisted with referrals, resolving grievances, access to services and providing information regarding services.

First-Year Target/Outcome Measurement: In 2014, the DMH will continue to operate the helpline.

Second-Year Target/Outcome Measurement: In 2015 the DMH will continue to operate the helpline.

Description of Collecting and Measuring Changes in Performance Indicator: Information collected from the DMH database

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Goal 3: To increase funds available for community services for children with serious emotional disturbance and adults with serious mental illness

Strategy: The Department of Mental Health will seek additional funds in its FY 2014 budget request for community support services for children with serious emotional that disturbances and adults with serious mental illness. Budget requests for the year that begins July 1, 2013 and ends June 30, 2014, were due August 1, 2013. The DMH plans to request sufficient funding to maintain the current level of operations, in addition to obtain sufficient funding to begin expanding community-based services as outlined in the DMH Strategic Plan. A copy of that plan is available on the DMH website (www.dmh.state.ms.us). This plan has a heavy emphasis on expanding community services, while concurrently reducing residential services. The main issue standing in the way is "bridge funding." That is, to successfully move an inpatient program to a community program, one must first create the community program (which means increased expenditures for awhile because both the community program and the institutional program must exist for the transition period), and the individual served must also have an adequate place to live and access to transportation once discharged from residential care. Bridge funding will almost certainly be a part of the budget request.

Performance Indicator: Inclusion of request for increased state funds to support community mental health services for children in the FY 2014 DMH Budget Request

Baseline Measurement: In FY 2012, the DMH presented a request for $40,410,000 additional general fund dollars for mental health services which included full funding of CMHC Medicaid match, full funding of pre-evaluation screenings, and funding needed to

assist in accomplishing the DMH Strategic Plan objectives. The DMH did not receive any additional funding. By the end of the 2012 legislative session, the DMH sustained a $835,000 cut in funding.

First-Year Target/Outcome Measurement: In 2014, the DMH will continue to request and increase in state funds to support community mental health services for children included in the DMH budget request.

Second-Year Target/Outcome Measurement: In 2015, the DMH will continue to request and increase in state funds to support community mental health services for children included in the DMH Budget Request.

Description of Collecting and Measuring Changes in Performance Indicator: DMH Budget Request, FY 2014

***Footnote:** DMH has also advised legislative leaders of an investigation by the Justice Department to determine if Mississippi is violating the civil rights of consumers of mental health services, and has advised them that a supplemental budget request might be made to address findings if those findings are released during the legislative session.

SECTION III
PLANNED
EXPENDITURES

Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Activity	MH Block Grant	Medicaid	Other Federal Funds	State Funds	Local Funds	Other
1. Substance Abuse Prevention and Treatment						
a. Pregnant Women and Women Dependent Children						
b. All Other						
2. Primary Prevention						
3. Services						
4. HIV Early Intervention Services						
5. State Hospital						
6. Other 24 Hour Care						
7. Ambulatory/Community Non-24 Hour Care	$3,810,443.00			$20,323,375.00		
8. Administration (excluding Program and provider level)	$190,522.00					
9. Total	$4,000,965.00			$20,232,375.00		

SECTION IV
NARRATIVE PLAN

H. Trauma

The Department of Mental Health has integrated trauma screening practices into the initial assessment process for individuals receiving services. Mental health providers certified by the Department of Mental Health screen for trauma as required by the DMH Operational Standards. 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. Mississippi has two National Child Traumatic Stress Network Sites, Catholic Charities, Inc. and Region 13/Gulf Coast Mental Health Center currently operating the TIDES grant. The Division of Children and Youth Services conducted two statewide trainings on Trauma-Informed Care in 2012 and another statewide training is scheduled for February 25, 2013, with over 350 participants registered. In the last year, four presentations were made on Trauma-Informed Care at the Jackson State University Stepping Stones Conference, the Department of Mental Health Annual Joint MH/IDD Conference, and for staff and community partners of Region 4/Timber Hills Community Mental Health Center.

The Mississippi Department of Mental Health (DMH) 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 DMH 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 DMH expanded the campaign 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.

I. Justice

The DMH is currently working with the Department of Corrections to have mentally ill offenders enrolled in Medicaid so their benefits will be activated the day; or day after, their release from prison. This process should decrease the gap in services and in recidivism rates. Screenings are provided prior to adjudication and/or sentencing to individuals with mental and/or substance use disorders. Pre-evaluation screenings are done through the CMHCs prior to commitment hearings. The DMH is coordinating with the criminal and juvenile justice systems with respect to: diversion of individuals with mental and/or substance use disorders, behavioral services provided in correctional facilities, and the reentry process for those individuals.

Mississippi's first behavioral health court is located in Hattiesburg, MS. The new program specifically targets the special needs of misdemeanor offenders suffering with mental health issues. The DMH is coordinating with the Mississippi Department of Corrections to provide behavioral health services in correctional facilities prior to offenders’ release. Goals include: establishing Medicaid benefits, assistance with housing, provision of vocational classes, assistance in obtaining employment, and provision of a peer support specialist pre-release and post release. Offenders will have an appointment scheduled with

a doctor at the community mental health center and intensive case manager within one week of reentry into the community.

The MAYSI-2 is utilized by the youth courts and detention centers across the State of Mississippi. The score of the MAYSI-2 determines whether the youth receives a more comprehensive mental health assessment. Youth held in the detention centers have access to mental health services including individual and family counseling, community support services, and medication monitoring. Some areas of the state also offer Wraparound Facilitation and Peer Support Services in the juvenile detention centers.

The DMH Division of Children and Youth Services collaborates with the Division of Youth Services, Department of Human Services to implement Adolescent Opportunity Programs (AOP) across the state. An AOP is a community-based intervention to divert youth from further involvement with the juvenile justice system and the state operated juvenile correctional center. AOP programming includes social skills development, independent living skills, tutoring, mental health counseling, mentoring, etc.

J. Parity Education

The DMH is planning to utilize some of the final British Petroleum grant monies to certify trainers in Mental Health First Aid (MHFA). These certified trainers will be available to provide education through workshops to community leaders such as pastors, teachers, and civic groups, along with families and friends interested in learning more about mental health issues. With knowledge comes understanding. Communities that have a better understanding of mental health issues are shown to have less stigma around mental illness. Hopefully with more community understanding, those who suffer from mental illness will be receive assistance and support they need rather than eschewed by our schools, churches and the general public. The DMH is planning to certify trainers of MHFA in both the core and the youth versions. Certification training for MHFA is tentatively set for May 2013.

Plans to educate and raise awareness in Mississippi about parity could include partnering with the Mississippi Department of Education to incorporate a mental health awareness campaign in schools. The DMH has a grassroots network made up of private sector providers, individuals who have received services provided by DMH certified providers, and the family members of individuals suffering from mental illness. This existing network is a tremendous asset to DMH. A brief document outlining the parity provisions of recent mental health law could be created and distributed to interested individuals. The information in the document should include straightforward, uncomplicated information about parity and the effect and impact parity has on individuals receiving mental health services.

The National Association for Mental Illness (NAMI) has developed a program called Patriots for Parity, which educates military families and service members across the nation on available benefits. State officials in Wisconsin partnered with policy advocates to appeal their message to residents of their state. The State of Massachusetts directs individuals to resources where they can obtain more information about parity.

In Mississippi, The Division of Medicaid has implemented a Coordinated Care Program called Mississippi Coordinated Access Network (MississippiCAN). MississippiCAN is designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries. A partnership between the Division on Medicaid/MississippiCAN and DMH could increase awareness and improve education regarding parity issues in our state. In January of 2013, the two Coordinated Care Organizations responsible for providing services to the Mississippi Medicaid beneficiaries

who participate in the MississippiCAN program were invited to make presentations to the Mississippi State Mental Health Planning and Advisory Council. The two organizations presented information on their Plans (Magnolia Health Plan and United Healthcare Community Plan) to the consumers, family members, and state agency and community mental health center/non-profit provider representatives on the Council.

Plans to educate and raise awareness in Mississippi about parity could include partnering with the Mississippi Department of Education to incorporate a mental health awareness campaign in schools. In addition, collaboration between the DMH and the State Department of Insurance to highlight the importance of mental health coverage in the new state insurance exchange could also increase awareness and understanding of benefits.

K. Primary and Behavioral Health Care Integration Activities

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 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). Integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care is included in the DMH Strategic Plan.

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 2013, current membership includes: individuals representing adult mental health services, children/youth mental health services, alcohol and substance abuse services, intellectual and developmental disability services, Alzheimer's/dementia services, community services programs, nurse practitioners, the DMH medical director, representatives from the MS Association of Community Mental Health Centers, the MS Department of Health, a local federally qualified health center and the Mississippi Primary Health Care Association. Plans are underway to reach out to other potential partners, including the Office of Medicaid and the University of Mississippi Medical Center. By June 30, 2012, the IWG had developed a Baseline Document of all known integrated services within the state mental health system. Information from this document was shared at a statewide conference in October 2012. The IWG has 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 Division of Medicaid, the Mississippi State Department of Health, Pine Belt Mental Healthcare Resources, Warren-Yazoo Mental Health, the University of Southern Mississippi, the University of Mississippi Medical Center and various Community Health Centers (FQHCs). The MS Division of Medicaid applied for and received planning funding for development of a State Plan Amendment for Health Homes. To date, Medicaid has received 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.

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, the DMH facilitated meetings between a number of Community Mental Health Centers with the MS Primary Health Care Association to collaborate on applications for the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant. These 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 three Community Mental Health Centers submitted grants, none of them were funded. Also in 2012, the DMH partnered with the State Department of Health to submit a CDC Community Transformation Grant application. This initiative was entitled *MS-CHASE (MS Creating Health Active State Employees)* and would have provided a structure for physical and behavioral wellness and treatment, as needed, on a statewide basis for State Employees. It was not chosen for funding.

Although none of the above-mentioned 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 will host a Spring Symposium entitled Improving *Quality of Life through Integrating Primary Care and Behavioral Health*. This day-long event is 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 MS Department of Health biennial statewide conference will be held in May 2013. It is entitled *Empowering Communities for a Health Mississippi: Creating a Holistic Approach to health Communities*. For the first time, MDOH invited the DMH to partner with them to plan the conference and develop content on integrated services. An entire track of Patient-Centered Care and Behavioral Health sessions has been prepared.

The DMH has funded the development of two PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance abuse and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). The DMH requested additional funding from the MS State Legislature in 2012, but did not receive the requested funding. The DMH plans to continue to request additional funds and is also a key participant with the Gulf Region Health Outreach Program's Primary Care Capacity Project. This is another program 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.

The DMH works collaboratively with the MS Primary Health Care Association, the Mississippi Department of Health, the University of MS Medical Center (only teaching hospital in the State), the Community Mental Health Center system, various FQHCs and other providers to promote integrated 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. 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. The survey will collect data which will be used to identify the occurrence of tobacco, the usage among clients and how staff members deliver alcohol and drug services.

In addition, the DMH is currently 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 abuse and primary health care services are not all available at the same location on a statewide basis. Six Community Mental Health Center regions are equipped for and utilize Tele-Health services. Three of the CMHCs contract with local providers for this service and the other three contract with The University of Mississippi Medical Center. Two Community Mental Health Center regions report directly working with their local Community Health Center and only one of those was a formal agreement. Two Community Mental Health Center regions report 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 abuse services for SMI Adults and SED children/adolescents. Additionally, Region 3 offers lab services, pharmacy services and primary care services. Region 3 works with LabCorp to offer on-site lab services, operates a pharmacy which provides services at all clinic locations and provides primary care services. The primary care services are offered to residents of all counties within the Region 3 catchment area, via a two exam room mobile medical clinic which is certified as a Rural Health Clinic (RHC). The mobile medical unit is stationed in Lee County, Pontotoc County, Monroe County and Benton County throughout the week. The mobile unit is set up in the parking lots of our county mental health clinics. My Brother's Keeper, Inc., located in Jackson, Mississippi, recently opened the Open Arms Healthcare Center. Open Arms Healthcare Center was established to provide affordable and quality healthcare services to Mississippi's most vulnerable populations, with emphasis on the Lesbian, Gay, Bisexual, Transgender and Intersex community. As the first of its kind in Mississippi, Open Arms Health Care Center will offer all communities an opportunity to obtain culturally competent clinical, preventive, and mental health services in a safe and comfortable environment.

L. 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.

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 currently 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 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

M. 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 FY 2013-2017. The DMH has made a commitment to sponsor a Breakthrough Series Collaborative in order to more quickly and thoroughly test out and establish the essential components of this recovery and resiliency-based system of care for the public behavioral health system. Originally, the Breakthrough Series Collaborative methodology was developed by the Institute for Healthcare Improvement to make improvements in healthcare systems by shortening the lag time between scientific advancements and the adoption of best practices. The methodology involves bringing together faculty and implementation teams over a period of several months so that improvements can be rapidly investigated to support sustained change.

As teams aim to accomplish the mission of the collaborative, they will be able to track their progress utilizing the following goals:

1. Transform policy, organizational culture, and practice to reflect a recovery and resiliency framework

2. Identify and implement best-practice recovery and resiliency-informed assessments, planning tools, and interventions for adults
3. Align funding streams to support an effective service delivery system
4. Develop organizational infrastructure to support on-going monitoring and delivery of high-quality recovery and resiliency services
5. Facilitate authentic engagement and full partnership with the consumer and their support network to impact all phases of services

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.

Housing

Included in the DMH Strategic Plan are several objectives and benchmarks 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. Another benchmark the DMH is considering is the provision of some type of bridge funding for supported housing which will most likely be accomplished in conjunction with a housing finance entity in our state.

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 MPF 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. During 2012, each DMH residential program 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.

N. Prevention

The DMH will use some of the final British Petroleum grant monies to certify a cadre of trainers in Mental Health First Aid (MHFA). These certified trainers will be available to provide education through workshops to community leaders such as pastors, teachers, and civic groups, along with families and friends interested in learning more about mental health issues. Funds from the DMH Behavioral Health BP Grant Program have already provided valuable services, programs, and informational materials in many of the communities in Mississippi affected by the BP oil spill. MHFA training will enhance the progress that has already been made. Communities who have a better understanding of mental health issues are shown to have 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. DMH will have certified trainers of MHFA in both the core and the youth versions. Certification training for MHFA is tentatively set for May 2013 focusing on adults and September 2013 focusing on children and youth.

O. Children and Adolescent Behavioral Health Services

From 2006 -2012, a Mississippi System of care CMHI grant targeted youth/young adults diagnosed with co-occurring disorders. Through this initiative (commUNITY cares), several evidence-based practices were implemented and are now being expanded into other regions of the state. The EBPs include the Seven Challenges, Trauma-Focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy and Wraparound Facilitation. These models are monitored by the Department of Mental Health through program standards and certification. Wraparound Facilitation became part of the State's Medicaid Plan in July 2012; therefore, it is monitored by the Division of Medicaid as well. Additionally, the Bureau of Alcohol and Drug Abuse staff and the Division of Children & Youth staff are working on implementing an evidence-based practice for youth with co-occurring disorders in the local detention facility. This local initiative will serve as a pilot program and model for expansion into the other 17 youth detention centers across the state.

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 abuse specific assessment is also utilized in addition to the initial assessment.

In 2001, legislation was passed creating the Interagency Coordinating Council for Children and Youth and the Interagency System of Care Council (ISCC). Both Councils 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 abuse 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.

The Mississippi Trauma Recovery for Youth (TRY) project, funded through SAMHSA supports the validation of a strengths-based assessment tool for use with traumatized children and youth**.** TRY of Catholic Charities in Jackson, MS, is a member of the National Child Traumatic Stress Network (NCTSN). The Mississippi Trauma Recovery for Youth (TRY) Project, through a learning collaborative approach has trained clinicians in evidence-based practices such as Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In addition, the Division of Children and Youth Services partnered with the Division of Medicaid, MYPAC Program to begin state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. Both agencies are using the University of Maryland's Innovation's Institute training model which includes a three-day Wraparound 101 course, one-day Advanced Wraparound and a 12-18 month process for Coach/Supervision Certification.

P. Consultation with Tribes

The DMH Division of Children and Youth staff provided FASD-specific education, diagnosis and training to staff at Choctaw Behavioral Health Services. Training was provided to case managers, social workers, and other staff within the Choctaw Tribal Agency in August 2011. The primary goal of this effort was to provide FASD prevention and intervention services to families and children within the Choctaw Tribal Agency. Plans are also being developed to adapt or modify the FASD curriculum to be more appropriate for the Choctaw culture and educate Choctaw Behavioral Health staff to become facilitators to continue training newly hired staff and maintain their own training and updates long-term. As a result of the training provided, the clinical staff at Choctaw Behavioral Health has begun to screen the children and youth receiving services for prenatal alcohol exposure. It is the expectation that the screening results will be provided to the DMH to be included in the FASD screening data that is being collected by the DMH

The provision of FASD training to the Mississippi Band of Choctaws is an objective that has been included in the 2011-2013 FASD State Plan. Mississippi's FASD State Plan is developed and implemented by the Mississippi Advisory Council on FASD (MS AC-FASD) which is made up of representatives from at least fifteen state and local agencies and programs that have a direct interest and involvement in children and families who are

affected by FASD. The MS AC-FASD also includes a representative from the Band of Choctaws.

The Mississippi Trauma Recovery for Youth (TRY) Project, led by Catholic Charities, Inc., involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practices of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (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. The project also involves tracking of provision of services and treatment outcomes over a period of time. Participants in the collaboratives have included clinicians from the 15 CMHCs and the MS Band of Choctaw Indians Behavioral Health. In FY 2012 116 clinicians were trained in evidence-based practices.

The Department of Mental Health continues to have an individual from the Choctaw Tribe, participating on the Multicultural Task Force. Staff from the Division of Children and Youth is collaborating with a staff member from the Choctaw tribe on the upcoming 8th Annual Youth Leadership Conference scheduled for June 27-28, 2013. DMH staff will provide assistance in obtaining sponsorship and informational booths for the conference. The DMH Division of Children and Youth staff has also been asked to provide a presentation on working with Lesbian/Gay/Bisexual/Transexual individuals. The information for this presentation will be submitted to the Choctaw Community Planning Coalition for approval. Members of the Choctaw Tribe also participate in the annual Mississippi Day of Diversity initiative by the Department of Mental Health. Members of the tribe have presented on the customs, beliefs and practices in regard to mental health and shared personal stories regarding family members and friends diagnosed with a co-occurring disorder.

The Bureau of Alcohol and Drug Services (BADA) has a statewide Alcohol and Drug Abuse Advisory Council which meets quarterly. A member of the Council is the Director of Choctaw Behavioral Health, Choctaw Tribal Agency located in Philadelphia, MS. The Choctaw Tribal Agency works closely with BADA and administers two federal grants through the BADA office, prevention and workforce development. The SureTool, an internet substance abuse prevention database is utilized to gather specific information regarding Tribes. A representative from the Mississippi Band of Choctaw Indians currently serves on the Mississippi State Mental Health Planning and Advisory Council.

S. Suicide Prevention

The DMH, working in collaboration with the Department of Defense and local authorities, has specific initiatives to promote mental health awareness by providing information to active duty military, veterans, National Guard members, the Reserve and family members of the military on accessing needed mental health services. The SMHA serves on the Joint Behavioral Health Task Force and developed the military campaign, *Operation Resiliency*, which focuses on mental health awareness for returning veterans and their family members. *Operation Resiliency* will reach all National Guard units across the state through brochures, posters, and resource guides and 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. Resource guides have been distributed to 500 men and women in the National Guard.

The Bureau of Alcohol and Drug Abuse works closely with the Mississippi National Guard in prevention efforts with the MS public and private schools. A Colonel from the Guard serves on the State Alcohol and Drug Abuse Advisory Council.

Shatter the Silence: Suicide Prevention in the Elderly information cards are distributed through the Division of Alzheimer's educational activities. Information cards were distributed at the *13th Annual Conference on Alzheimer's Disease and Psychiatric Disorders in the Elderly*. A session about suicide prevention in the elderly was included in the 2012 Conference Agenda. Information cards are distributed at other DMH conferences, the MS Planning and Development District Annual Conference and are made available to service providers in greater quantities upon request. Suicide Prevention information is also distributed at workshops conducted by the Division of Alzheimer's Disease and Other Dementia, health fairs, caregiver support groups, and guest lectures at area colleges and universities. The Division of Alzheimer's has presented workshops and guest lectures on suicide prevention and has introduced the Suicide Prevention in the Elderly Tool Kit for Residential Communities to long term care centers statewide. Suicide Prevention is addressed as an objective in the State Operational Plan for the Division of Alzheimer's Disease FY 14 and has been included in years past as well.

The DMH's Office of Consumer Supports contracts with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in Mississippi. The federally funded NSPL routes callers from Mississippi to the DMH Office of Consumer Supports for crisis intervention, suicide prevention, and resource referrals. (See Appendix A: Mississippi Youth Suicide Prevention Plan.) DMH staff is reviewing a draft suicide prevention plan for adults, after which it will be revised as needed.

U. Technical Assistance Needs

Children's Services: Qualified staff continue to be needed on the state and local levels to implement Evidence-based Practices and children/youth functional assessments that would provide meaningful data on the program/client outcomes level. Currently, the DMH is utilizing resources from the System of Care Initiative and the two National Child Stress Traumatic Network sites in the state to train mental health providers in Trauma –focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Combined Parent Child Cognitive Behavioral Therapy (CBC-CBT) and Wraparound based on the University of Maryland's, Innovations Institute Model. The Learning Collaborative Model is being utilized for training on these EBPs which requires three, two day learning sessions and monthly phone calls. The Medicaid State Plan currently does not have an enhanced reimbursement rate for EBPs so incentives for providers to participate in the Learning Collaboratives are being explored.

The DMH Operational Standards now require children/youth mental health providers to conduct a functional assessment within 30 days of admission and six months thereafter to measure client's progress. The web-based version of the Child and Adolescent Functional Assessment Scale (CAFAS) was introduced in FY 2013 and will be implemented statewide in FY 2014.

Adult Services: The DMH has requested financial assistance to support a Health and Wellness Training for Certified Peer Support Specialist from the National Association of State Mental Health Program Directors (NASMPD). Technical assistance is needed by state staff to support and enhance our efforts to engage consumers and family members in

the planning, evaluation, and implementation of mental health services. Implementing the Pillars of Peer Support would be addressed in the technical assistance. The following Pillars that have not been addressed include: (1) a research and evaluation component that continuously measures the program's effectiveness, strengths and weaknesses and makes recommendations on how to improve the overall program; (2) opportunities for Peer Support Workforce Development that help identify and prepare candidates for participation in the training and certification process; and (3) a Culturally Diverse Peer Workforce that reflects and honors the cultures of the communities served.

Transitional and supported employment was an integral part of the Psychosocial Rehabilitation/Clubhouse Program. Due to Medicaid regulations, the Clubhouse Program was discontinued in July, 2012. Staff need technical assistance in finding placement and developing job opportunities for individuals seeking employment.

V. 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 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, Mississippi Department of Human Services/Division of Youth, and the Mississippi Department of Public Safety will be submitted with the state plan application.

These State agency partners provided the following information:

Division of Medicaid, Office of the Governor (Lead Agency)

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 a 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 is 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 outcomes from the MYPAC program are expected to be shorter lengths of stay at PRTFs, a decrease in PRTF beds over time, more coordinated treatment for youth with 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 is continuing to work with the Division of Medicaid to develop a proposed State Plan Amendment and/or a waiver for submission to the Centers for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community based services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Bureau of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults.

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.

Department of Mental Health Bureau of Alcohol and Drug Services

Substance abuse services for adults and children are administered by the MS Department of Mental Health, Bureau of Alcohol and Drug Services (BADS). CMHCs free-standing programs and two state-operated psychiatric hospitals are the primary providers of alcohol and drug prevention and rehabilitation treatment services administered by the Bureau of Alcohol and Drug Services. The Bureau of Alcohol and Drug Services address the needs of adults described below:

General Outpatient Services: This program is appropriate for individuals whose clinical condition or environmental circumstances do not require an intensive level of care. The duration of treatment is tailored to individual needs and may vary from a few months to several years.

Intensive Outpatient Services: These services are directed to persons who need more intensive care but who have less severe alcohol and drug problems than those housed in residential treatment. IOP services enhance personal growth, facilitate the recovery process and encourage a philosophy of life which supports recovery.

Chemical Dependency Unit Services: Inpatient or hospital-based programs offer treatment and rehabilitation services for individuals whose substance use problems require a medically monitored environment. These may include: (a) patients with drug overdoses who cannot be safely treated in an outpatient or emergency room setting; (b) patients with withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive

treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes detoxification, assessment and evaluation, intervention counseling, aftercare, a family support program and referral services. Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance use. The program is designed to break the cycle of being frequently hospitalized by treating the substance use simultaneously with the mental illness.

Primary Residential Services: The Primary Residential Treatment Program is a twenty-four hour, seven days a week onsite residential program for adult males and females who are addicted to alcohol/drugs. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive than 'primary' but who do not meet the clinical criteria for hospitalization. Typically, primary residential treatment programs operate on a 30-day cycle.

Transitional Residential Services: The Transitional Residential Treatment Program is a less intensive program for adult males and females, who typically remain from two to six months depending on the individual needs of the client. The client must have completed a primary treatment program before being eligible for participation in a transitional program.

Referral Services: The Bureau of Alcohol and Drug Services updates and distribute the current edition of the Mississippi Alcohol and Drug Prevention and Treatment Resources directory nationwide. The directory is also on the DMH Internet web site for those in need of services.

Employee Assistance Program: The Employee Assistance Coordinator updates and distributes the Employee Assistance Handbook to representatives of state agencies and organizations. The handbook entails the development of an employee assistance program including federal and state laws regarding a drug free workplace. The coordinator continues to provide EAP trainings across the state.

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 MS 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.

Justice Services

The DMH has an agreement with the MS Department of Public Safety. Professional mental health staff from the CMHCs, provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. The DMH's certified trainers, throughout the state, continue to conduct in-service training.

In FY 2012, the DMH made funding available to 15 CMHCs to help support provision of law enforcement training. Twelve CMHCs applied for and received funding. As of June 2012, the CMHCs reported conducting 38 training sessions, with 692 law enforcement officers trained. This funding has been made available again in FY 2013 and 12 CMHCs have applied for and received the funding.

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, and DMH. LCCP has completed two 40 hour training sessions certifying approximately 24 sheriff's deputies and police officers. The LCCP is still trying to establish a single point of entry for the CIT program.

The City of Hattiesburg, with assistance from Pine Belt Mental Health (PBMH), established the state's first behavioral health court in FY 2011. The Hattiesburg Behavioral Health Court (HBHC) currently has 33 participants enrolled in the program.

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, cybercrime (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 abuse 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 that determines the appropriate special education and related services (including transition services) and placement of student with disabilities. Any related service required by a student 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: communication services, counseling services, physical therapy, occupational therapy, behavior interventions, assistive technology evaluations and devices, parent education and training, adapted physical education and transportation. All districts in the State must provide all services as determined by the IEP Committee.

Updated 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 could include instruction, related services/training, community experiences, adult living/employment skills and when appropriate, acquisition of daily/independent living skills and functional vocational evaluation. Community-based activities, including job shadowing, on-the-job training, as well as part-time employment, are also provided if determined appropriate by the IEP Committee. The IEP must also have a desired post-school outcome statement. This statement should address areas of post-school activities/goals, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living and/or community participation.

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 flouride varnish applications to prioritized populations, such as children enrolled in Head Start programs. The Public Water Fluoridation Program is a collaboration with the Bower Foundation to provide grant funds to public water systems to install community water fluoridation programs.

The Mississippi State Department of Health (MSDH) recommends that every child begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. The MSDH Office of Oral Health can provide guidance on how to perform an oral health risk assessment and several risk assessment tools are available through the American Academy of Pediatrics, the American Association of Pediatric Dentistry, and the American Dental Association. Groups at higher risk for having dental caries, or tooth decay, include children with special health care needs, children of mothers with a high dental caries rate, children with demonstrable dental caries, plaque, demineralization, and/or staining, children who sleep with a bottle or breastfeed throughout the night, later-order offspring, and children in families of low socioeconomic status. The MSDH recommends that infants in risk groups should be referred to a dentist as early as 6 months of age and no later than 6 months after the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home with education and early prevention services.

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

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 abuse 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.

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

A representative of the Mississippi Department of Rehabilitation Services continued to

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

Specific examples of vocational/employment services accessed for youth by individual children's community mental health service providers include: independent living skills training, occupational therapy and development, GED programs, job training and placement, interviewing training, life skills assessment, supported employment, job coaching, work readiness programs, basic technical skills training, resume and application assistance and technology training. These services are provided through a variety of state and local resources and providers, which can vary across communities, such as: Job Corps, the Mississippi State Employment Security Commission, WIN Job Centers, the Mississippi Department of Rehabilitation Services, local school districts, Recruitment/Training Program of Mississippi, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, AbilityWorks, Inc. of Mississippi, county vocational-technical centers, Youth Challenge Program, the Mississippi Department of Human Services, MIDD, MIDD West Industries, Pine Belt Mental Healthcare Resources Transitional Outreach Program, Pine Belt Graphics, PALS, Youth Challenge, Jackson State University, and community colleges.

General vocational rehabilitation services are available to individuals with serious mental illness through referral to the Office of Vocational Rehabilitation in the Mississippi Department of Rehabilitation Services. Once an individual's eligibility for services is established (as per eligibility criteria and guidelines of the Office of Vocational Rehabilitation), services are provided on an individualized basis, pursuant to a formal plan developed with the eligible individual. General vocational rehabilitation services include a range of services from diagnosis and evaluation to vocational training and job placement. Individual referrals can be made to VR/Supported Employment counselors who utilize VR case service funds to pay for services outlined on the Individualized Plan for Employment (IPE), which could include Job Coaches, Job Development and other services. These VR/Supported Employment counselors work for the Mississippi Department of Rehabilitation Services, and it should be noted that such referrals for services usually, but do not always, result in the use of job coaches. The DMH hopes the use of job coaches or other employment support options for individuals with mental illness will increase; this program component, however, is under the supervision and regulations administered by the Mississippi Department of Rehabilitation Services. Additionally, individuals eligible for general vocational rehabilitation services might receive assistance with medical and/or health needs, special equipment, counseling, educational training, or other assistance that would enhance employability.

The DMH plans to continue increased collaboration with MS Department of Rehabilitation Services staff to explore options for expanding supported and competitive employment options for individuals with serious mental illness that might be available through that agency. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, has continued to participate on the Transitional Age Services Task Force and provided members with information on meeting the employment needs of youth/young adults in the transitional age range (14 to 25 years). The Office of Vocational

Rehabilitation also participates on the Transportation Coalition. The DMH Division of Community Services has a representative on the board of APSE, Mississippi Advancing Employment Connecting People, MS APSE, which held its second conference, Opening Doors to Employment…Making It Happen.

Representatives of the Mississippi Department of Rehabilitation Services Ticket to Work Program unit have served as an additional resource for employment support. The Ticket to Work Program Unit is the centerpiece of federal legislation signed into law in December 1999 under the Ticket to Work and Work Incentives Improvement Act of 1999. The legislation is designed to increase choices for SSA beneficiaries in obtaining rehabilitation and vocational services; to remove barriers that required people with disabilities to choose between health care coverage and work; and, to assure that more disabled beneficiaries with disabilities have the opportunity to work. One of the key provisions of the Ticket legislation is the Ticket to Work Program, which requires the Social Security Administration to issue tickets to SSA beneficiaries with disabilities. These tickets may be used to obtain vocational rehabilitation, employment, or other support services from an approved provider of their choice. The Social Security Administration's final regulations for the Ticket to Work Program were published in the May 20, 2008, Federal Register and became effective July 21, 2008.

Educational Services may also be accessed by community mental health centers for some adults with serious mental illness. These services generally include GED and adult literacy, and/or vocational training programs provided through community colleges, local schools, and/or volunteer organizations. Specific Vocational/Employment/Educational Services are provided to adults with serious mental illness, in addition to or in conjunction with vocational rehabilitation services and consumer education programs.

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.

Mississippi Families As Allies for Children's Mental Health, Inc.

The Division of Children and Youth continues to provide financial support and technical assistance to Mississippi Families As Allies, Inc., (MS FAA). MS FAA has built a statewide parent support, education and advocacy network for families of children who have emotional/behavioral difficulties or mental illness. Funding from the Department of Mental Health continues to help support the employment of Family Support Partners and to support respite services to care givers, while also providing support for administration and clerical services, training, and family service expansion.

Major goals of the MS FAA are to enhance and develop levels of emotional support available to families, to provide a systematic, structured process for the transfer of knowledge for families and professionals and to provide external advocacy for service development. Services offered through this growing network include: a toll-free number for easy access to the main office and to local MS FAA Chapters; support and case advocacy for families and children via Family Partners; information and referrals; educational forums and workshops; a resource library of materials about children with emotional or behavioral problems; FACTS for Families, available on the MS FAA website and by mail; leadership training and education for parents and youth. The Division of Children and Youth Services continues to refer individuals and service providers requesting information on available family education/training to MS Families as Allies for Children's Mental Health Services, Inc. MS FAA is also the official administrator for training, services and quality assurance for in-home and group respite.

Under the Statewide Family network grant, the MS FAA Family Partners provide technical assistance to families on developing their own network and leadership capacity. This support helps families participate on MAP Teams and make improvements to their own local Systems of Care. In this way, MS FAA integrates its Family Education, Family Support and Local Network Development initiatives funded with federal resources. MS FAA has continued to support families' participation in local, regional and national workshops and conferences via parent stipends, child care and respite services, and funding of registration and travel costs, as funding is available.

W. State Behavioral Health Advisory Council

LIST OF MS PLANNING AND ADVISORY COUNCIL MEMBERS

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Ms. Harriette P. Mastin	Family member (Adult)	Self; Member NAMI Board; Member Warren-Yazoo Advisory Council; Support Group Leader MS Advisory Coalition; Provider Education Teacher Visions Family to Family	11880 Highway 61 South Vicksburg, MS 39180 601.630.9470 (h)	Mastin8@juno.com
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Ms. Lisa Seaton	Other	Optum Health Behavioral Solutions United Healthcare Community Plan - MS	Optum Health Behavioral Solutions 795 Woodlands Parkway, Suite 301 Ridgeland, MS 39157 800-548-6549 ext. 67189 601.953.0105	Lisa.seaton@optum.com
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Ms. Tonya Tate	Family Member (Adult)	Self	152 Edward Owens Drive Terry, MS 39170 601.954.2421 (o) 601.849.4733 (f)	ttate@bellsouth.net
Ms. Karla Tye	Other (Children)	Executive Director Children's Advocacy Centers of MS	P.O. Box 5348 Jackson, MS 39296-5348 601.940.6183 (o) 228.424.2874 (c)	ktye@mschaptercacs.org
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Mr. Larry Waller (President)	Family Member (Adult)	Self	11085 Old DeKalb Scooba Rd. Scooba, MS 39385 662.476.8035 (h) 601.940.0713 (c)	tlwaller@bellsouth.net
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Ms. Bonlitha Windham	Medicaid (State Employee)	Division of Medicaid	Division of Medicaid 550 High Street Walter Sillers Bldg., Suite 1000 Jackson, MS 39201 601.359.6114 (o) 601.576.4163(f)	Bonlitha.Windham@medicaid.ms.gov
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Y. Comment on the State Plan

The MS Planning and Advisory Council was provided the FY 2014-2015 Draft Plan areas of the focus at their January, 2013 meeting. The FY 2014 -2015 Draft Plan was presented to the State Board of Mental Health for approval at their February, 2013 meeting.

Public notices of the availability of the Draft Plan for 30 days' public review and comment, from February 15, 2013 through March 17, 2013, were published in major newspapers across the state. Public notices indicated that the Draft Plan was available at the 15 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 mental retardation, 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 will be 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 will 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 MS Planning and Advisory Council met in March, 2013 and approved the final FY 2014 -2015 State Plan. Copies of the final FY 2014-2015 State Plan will be disseminated to entities and individuals who received a Draft Plan (indicated above), directors of agencies/entities represented on the Council (if agency staff other than the director serves on the Council), and other individuals/entities who request a copy of the final Plan.

The final FY 2014-2015 State Plan will be submitted to CMHC prior to September 1, 2013. The Plan will also be available throughout the year on the DMH's website and through the state's depository libraries system.

SECTION V
ATTACHMENTS

APPENDIX A

APPENDIX B

APPENDIX C