

FY 2010 MISSISSIPPI STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES

FOREWORD

The Fiscal Year 2010 Mississippi State Plan for Community Mental Health Services was developed by staff of the Mississippi Department of Mental Health, in collaboration with the Mississippi State Mental Health Planning and Advisory Council. The Council serves in an advisory capacity to the Department in identifying service needs, in updating annual objectives to meet those needs, and in reviewing and monitoring progress on implementation of objectives throughout the year. The Mississippi Department of Mental Health greatly appreciates the commitment and work of Council members, and primary consumers from across the state. Their contributions to the ongoing planning process are key to continued progress in improving availability and accessibility of services for adults with serious mental illness and children with serious emotional disturbance. This State Plan document represents the cumulative long-range planning efforts of the Council and the Department of Mental Health in setting forth and pursuing a vision for an ideal comprehensive system of community mental health services for children with serious emotional disturbance and adults with serious mental illness in Mississippi. The Plan also addresses criteria for state plans included in federal law, as required in the state's application for Center for Mental Health Services Block Grant funds.

A Note About Funding: The FY 2010 State Plan includes objectives related to state funds, as well as use of other resources for community mental health services. Included under Criterion #5 in the Children's Plan and under Criterion #5 in the Adult Plan are objectives to request additional state funds for the 2011 fiscal year. Changes indicated under these criteria also reflect projected use of CMHS Block Grant funds in FY 2010, including the decrease in FY 2009 (current year) CMHS Block Grant funds.

Because the State Plan is considered a working document, the public is encouraged to submit comments to:

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Comments to the draft FY 2010 State Plan received after the comment period (July 3, - August 1, 2009) will be considered in development of the FY 2011 Plan.

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SECTION I. Description of the State Service System

General Description of the State Population - According to 2000 U. S. Census figures, Mississippi has a population of 2,844,658. The state has a significant minority population, with an estimated 39% of its citizens identified as nonwhite. Of the total number of nonwhite individuals, approximately 94% are African-American. The majority of Mississippians (approximately 61%) are between the ages of 18 and 64. Twenty-seven percent of the population are below 18 years of age, and approximately 12% are 65 years of age or older. In 2000, 48% of the population was male and 52% was female.

The 1990 U. S. Census indicated that in 1989, 20.2% of Mississippi families lived below the poverty level. According to the 2000 U.S. Census, in 1999, 19.9% of individuals in Mississippi lived below the poverty level, and 16% of Mississippi families lived below the poverty level. The 2000 Census also indicated that 22.2% of families with related children under 18 years of age lived below the poverty level in 1999. Over the last decade, Mississippi has shown increases in income and signs of decreasing unemployment. The per capita income of Mississippi in 1991 was reported to be \$13,328, which was 69.8% of the national average (*Handbook of Selected Data, 1993*); however, based on the 2000 U.S. Census, per capita income had risen to \$15,853. In 1991, unemployment was 8.6% (*Handbook of Selected Data, 1993*). The moving 12-month average unemployment rate for the state as of March 2009 was 7.7%, with the number of unemployed averaging 101,000 and the number of employed (excluding the military) averaging 1,216,200. (The average unemployment rate for the month of March was 9.4%). Mississippi Department of Employment Security, May 2009).

A rural state, only 14% of Mississippi's 47,233 square miles is urbanized. The areas of the state where its population are concentrated are in the west central area of the state (the Jackson metropolitan area) and on the Gulf Coast. Of its 82 counties, 21 are designated as 100% rural, based on rural and urban designations resulting from 2000 U.S. Census data.

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, which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The statute placed into one agency mental health, alcohol/drug abuse, and mental retardation programs, which had previously been under the direction of the State Board of Health, the Interagency Commission on Mental Illness and Mental Retardation, the Board of Trustees of Mental Institutions, and the Governor's Office. The creation, organization, and duties of the Mississippi Department of Mental Health are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23. The network of services comprising the public mental health service system includes three major service delivery components: regional community mental

health/mental retardation centers, state-operated facilities, and other nonprofit service agencies/organizations. (See description of regional/sub-state programs, CMHCs/resources of cities/counties that follows).

Organizational Structure of the Mississippi Department of Mental Health

The Department of Mental Health provides leadership in coordinating mental health services within the broader system through both structural and functional mechanisms. The Mississippi Department of Mental Health (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.

Within the Department, the Executive Director directs all administrative functions and implements policies established by the State Board of Mental Health. The Office of Constituency Services, the Director of Disaster Preparedness and Response and the Director of Public Information report directly to the Executive Director.

The Division of Constituency Services is responsible for the documentation, investigation and resolution of all complaints/grievances regarding state and community mental health/mental retardation facilities that are received from individuals receiving services, family members and the general public. In addition, the Division of Constituency Services operates and maintains a computerized database to provide information regarding services for persons with mental illness, mental retardation and substance abuse/dependence to callers through a toll-free help line, which is available 24 hours a day, seven days a week.

The Division of Disaster Preparedness and Response, which carries out MDMH's responsibilities as outlined in the *Mississippi Comprehensive Emergency Management Plan*, refines DMH's statewide disaster response system and creates and maintains the agency's disaster response plan. This division assists the DMH-operated facilities and local community mental health centers with disaster preparedness and response efforts. Additionally, this division is responsible for the implementation of youth suicide prevention efforts that include public awareness, training and the promotion of evidence-based practices to prevent suicide. The Division also works closely with the two National Child Traumatic Stress Network sites in Mississippi to promote trauma-informed care in the public mental health system.

The Division of Public Information is responsible for providing presentations and other public information requested by the general public, including individuals receiving services or families, media representatives and elected officials.

The Department of Mental Health has seven major bureaus: the Bureau of Administration, the Bureau of Mental Health (oversees six DMH-operated facilities and seven state crisis centers), the Bureau of Community Mental Health Services (includes community mental health for adults and children, Alzheimer's Disease/other dementia services and the Division of Planning), the Bureau of Alcohol and Drug Abuse, the Bureau of Intellectual and Developmental Disabilities, Bureau of Interdisciplinary Programs, and the Bureau of Workforce Planning and Development. The Department has a small state Central Office staff, which currently includes 94 employees (for all administrative, monitoring and service areas).

The Bureau of Community 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 Division of Planning provides administrative support to the Mental Health Planning and Advisory Council and supports Bureau of Community Services staff in developing the State Plan and other planning, training and research activities. For example, the Division oversees the provision of pre-evaluation screening training and is working to address the development of a strategic plan for housing. The Bureau of Community Mental Health Services provides a variety of services through the following divisions.

The Division of Accreditation and Licensure for Mental Health is responsible for coordination and development of minimum standards for community programs that receive funds through the authority of the Department of Mental Health, as well as the coordination of review, monitoring, and certification processes to ensure that all community programs meet those minimum standards. The Division works with staff of other service divisions in the Central Office to implement this ongoing program monitoring process.

The Division of Mental Health Community Services has the primary responsibility for the development and maintenance of community-based mental health services for adults. These services are currently provided through the 15 regional community mental health centers and the community services divisions of the two comprehensive state psychiatric hospitals. The priority population addressed by the Division is adults with serious mental illness. An array of treatment and support services are available through the public community mental health system. The major goal of the Division of Community Services in providing this network of community-based services for adults with serious mental illness is to make available the treatment and support needed by individuals with serious mental illness, which may vary across time. Additionally, the Division of Community Services develops and conducts training and staff development in areas specific to services for adults with serious mental illness.

The Division of Children and Youth Services is responsible for planning and developing programs for children and youth with serious emotional disturbances in Mississippi. The staff of the division direct, supervise, and coordinate the implementation of Department-funded children and youth mental health programs operated by community service

providers in the state. The division develops and supervises evaluation procedures for these programs to ensure their quality and oversees the enforcement of certain governmental program regulations, including DMH guidelines and standards for services. Community mental health services for children are currently provided through the 15 regional community mental health centers and a number of other nonprofit agencies/organizations funded through the Department of Mental Health. Additionally, the Division develops and conducts training in the areas determined to require new or ongoing training/staff development.

The Division of Consumer and Family Affairs promotes the empowerment of individuals and families with mental health needs through education, support and access to mental health services. The Division works closely with individuals receiving mental health services and family members, as well as with consumer-operated programs, advocacy and self-help organizations around the state.

The Division of Alzheimer's Disease/Other Dementia is responsible for developing and implementing state plans for the purpose of assisting with the care and treatment of person with Alzheimer's disease and other dementia. The Division is overseeing the development of adult day programs for these individuals, two of which are currently funded and serving as pilot projects for MS. The Central MS Regional Center operates one program in Newton, and LifeHelp, Region 6 Community Mental Health Center, operates one in Greenwood. The Division also develops educational and training programs for family members, care givers and service providers and has satellite offices in Magee, Oxford and Long Beach.

The Division of Community Mental Health Services for Adults, the Division of Children and Youth Services, and the Division of Alzheimer's Disease/Other Dementia work with the Division of Accreditation and Licensure, the Bureau of Interdisciplinary Programs and the Bureau of Administration to develop and monitor implementation of Department of Mental Health minimum standards and guidelines for community mental health services.

The Bureau of Alcohol and Drug Abuse is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with alcohol and/or drug abuse problems, including state Three-Percent Alcohol Tax funds for the Department of Mental Health. The overall goal of the state's substance abuse 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 aftercare services. Community-based alcohol/drug abuse services are provided through the regional community mental health centers, state agencies, and other nonprofit programs.

The Prevention Services Unit is responsible for the administration of the federally required prevention portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and discretionary prevention funds such as the Strategic Prevention Framework State Incentive Grant. Services target the delay, reduction and prevention of alcohol, tobacco and other drug (ATOD) use. Effective prevention services decrease the

need for treatment and provide for a better quality of life. Effective ATOD prevention is a proactive process that involves interacting with people, communities, and systems to promote the programs aimed at creating and reinforcing conditions that promote healthy behaviors and lifestyles. Funding is provided through the 15 community mental health/mental retardation centers and 13 other community-based private/public nonprofit free-standing organizations. Programs use their funding to provide direct services to the communities in which they reside. Some organizations, such as DREAM, Inc. of Jackson, DREAM of Hattiesburg and Jackson State University's Alcohol and Other Drug Studies Center utilize a portion of their funding to increase capacity statewide by providing technical assistance and workforce development activities to prevention programs as a part of their contracts with the Division of Alcohol and Drug Abuse.

The Bureau of Mental Health oversees the state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services and the state crisis centers, as well as the Central Mississippi Residential Center and the Specialized Treatment Facility, a specialized treatment facility for youth with emotional disturbances whose behavior requires specialized treatment. (See description of regional/sub-state programs, CMHCs/resources of cities/counties that follows).

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 provides three major services, including accounting, auditing and information/data management. The Division of Information Systems (which provides support to the Bureau of Mental Health, the Bureau of Community Services and its service provider network in data management (as described in the State Plan) is part of the Bureau of Administration.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for individuals in the state with mental retardation/developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive regional centers for individuals with developmental disabilities, one center for adolescents with mental retardation whose behavior requires specialized treatment, regional community mental health/mental retardation centers, and other nonprofit community agencies/organizations that provide community services. More detailed descriptions of the services/functions of the Bureau of Intellectual and Developmental Disabilities are available through other reports/documents of the DMH.

The Bureau of Interdisciplinary Programs coordinates the collection of information from DMH facilities, DMH divisions, other state agencies or the federal government and coordinates the development of reports to the State Board of Mental Health. The Bureau Director of Interdisciplinary Programs also serves as the liaison to the Board and Executive Director for all programmatic Bureaus to assure that all information is presented in a consolidated manner. The Bureau also is responsible for coordinating the

various divisions of the Central Office in revising the Minimum Standards for Mental Health Services as needed and for ensuring that programs are monitored consistently.

The Bureau of Workforce Planning and Development assures the smooth flow of communication between the human resource, staff training and staff certification functions and provides a formal way to develop strategic plans for staffing needs for the future. The Bureau advises the Executive Director and State Board of Mental Health on human resource and training needs of the agency, assists in educating the Legislature as to budget needs, oversees the development and implementation of a formal succession planning program and serves as liaison for DMH facilities to the State Personnel Board. The Division of Professional Licensure and Certification (which develops and implements licensure and certification programs for mental health (and other) staff, as described in the State Plan, is in this bureau. Also in this bureau is the Division of Professional Development.

Administration of Community-Based Mental Health Services

State Level The major responsibilities of the state are to plan and develop community mental health services, to set minimum standards for the operation of those services it funds, and to monitor compliance with those minimum 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. As described throughout the State Plan, 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, such as the MS State Mental Health Planning and Advisory Council; the Regional Commissions Group, members of which include the governing boards or commissions of community mental health centers; and, various task forces and committees that engage in ongoing efforts to improve the service system (described in the State Plan).

State Certification and Program Monitoring The Mississippi Department of Mental Health ensures implementation of minimum standards for community programs certified through the authority of the Department of Mental Health. Standards have been developed by the Department of Mental Health, approved by the State Board of Mental Health, and registered with the Mississippi Secretary of State's Office. The standards establish minimum requirements for programs in organization, management, and in specific service areas to attempt to assure the delivery of quality services. The Department ensures implementation of services that meet established minimum standards through its ongoing certification and site review process. Reviews are conducted by representatives from the Division of Community Services, the Division of Children and Youth Services, the Bureau of Alcohol and Drug Abuse Services, and the Division of Accreditation and Licensure. All community programs receiving funding through the Department must also submit monthly reports with their requests for reimbursement, which include service delivery and financial information. Bureau of Administration staff

perform fiscal audits of programs receiving funding through the Department of Mental Health.

State Role in Funding Community-Based Services The authority for funding programs to provide services to persons in Mississippi with mental illness, mental retardation, and/or alcohol/drug abuse problems by the Department of Mental Health 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 MS Department of Mental Health is a general state tax fund agency. Section 41-4-7(1) of the MS Code states that the Department of Mental Health is:

"to serve as the single state agency in receiving and administering any and all funds available from any source for the purpose of training, research and education in regard to all forms of mental illness, mental retardation, alcoholism, drug misuse and developmental disabilities, unless such funds are specifically designated to a particular agency or institution by the federal government, the Mississippi Legislature, or any other grantor."

The FY 2010 State Plan includes objectives related to state funds that will be appropriated for specific purposes by the State Legislature in 2009. Also included under Criterion 5 in the FY 2010 State Plan are objectives to request additional state funds for the 2011 fiscal year. Criterion 5 also reflects projected use of federal Community Mental Health Services (CMHS) Block Grant funds in FY 2010, including a decrease in FY 2009 (current year) CMHS Block Grant funds. The DMH administers and grants to local providers funding from the federal CMHS block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as the PATH program). The DMH also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers.

Agencies or organizations submit to the Department 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. Applications for funding are reviewed by staff in the DMH, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP, (2) the applicant's provision of services compatible with established priorities, and (3) availability of resources.

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

As mentioned above, 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 (described previously); 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. (See section that follows on how the State mental health agency provides leadership in coordinating mental health services within the broader system.)

Summary of Areas Previously Identified by State as Needing Attention

Areas on which Attention was focused in FY 2009 for Services for Children with Serious Emotional Disturbance

- Continued funding, monitoring of implementation and training of local MAP teams as well as plans for expansion to those counties with no access to a MAP Team.
- Continued collaboration with the Department of Human Services (DHS), Division of Youth Services in the implementation of Adolescent "A" Teams for those youth with SED who are involved in the juvenile justice system. Additionally, Division staff continued collaboration with DHS in the training, development, and implementation of Adolescent Offender Programs (AOPs) in those counties that do not already operate an AOP.
- Continued training of local service providers and cross agency training on mental health issues in youth, system of care development, strengths-based assessment, a wrap around approach to services, and trauma-focused cognitive behavior therapy, with focus on implementation of these concepts in the field.
- Continued focus on youth suicide prevention activities, including quarterly meetings of the Youth Suicide Prevention Advisory Council, training on ASIST and safeTALK practices, information dissemination, coordinating workshops and conferences on youth suicide prevention, collaboration with local school districts, and continued implementation of the statewide youth suicide prevention plan.
- Continued work by the members of the Interagency System of Care Council on the evaluation of policies and procedures and facilitating cross-training opportunities across agencies serving youth and families.
- Increased work on the implementation of the Fetal Alcohol Spectrum Disorder

(FASD) project and training on the identification, screening, and assessment of those youth, ages birth -7 years of age, who are at-risk or may exhibit symptoms of FASD. Continued implementation of the FASD state plan and quarterly meetings of the state FASD Advisory Council.

- Increased participation and collaboration with the local System of Care project, commUNITY cares, in the implementation of evidence-based practices, cultural competency training, sustainability, evaluation, and youth involvement.
- Work with the two National Child Traumatic Stress Network sites in Mississippi to promote the provision of trauma-informed care in the public mental health system.

Areas on which Attention was focused in FY 2009 for Services for Adults with Serious Mental Illness

- Continuing efforts to expand crisis intervention services. The Department of Mental Health continued to work with the Mississippi Legislature, which authorized the piloting of one state crisis center (in Grenada), shifting its operation by Mississippi State Hospital to operation by a community mental health center during FY 2010. The DMH plans to further expand this model to all crisis center regions within five years.
- Continuing activities to strengthen family education and support activities.
- Continuing work to strengthen consumer education activities.
- Maintaining availability and continuing efforts to improve the quality of clubhouse psychosocial rehabilitation services throughout all service regions of the state and expanding the number of ICCD certified clubhouses to a minimum of one in each community mental health region in the state.
- Maintaining availability, improving the quality through training and technical assistance and facilitating further development of psychosocial rehabilitation services for elderly persons throughout all service regions in the state, including community-based services and services for individuals in nursing homes.
- Creating and maintaining more person-directed case management services for individuals with serious mental illness by incorporating person-centered planning in case management orientation provided by the Department of Mental Health.
- Developing and implementing new protocols for providing intensive case management in all regions of the state.
- Continuing to monitor and refine new case management service options.
- Continuing efforts to implement changes to support specialized programs for

- persons with mental illness who are homeless.
- Continuing initiatives to improve evidence-based services for individuals with co-occurring disorders of substance abuse and mental illness, including increasing efforts to provide training and address the full integration of services for individuals with co-occurring disorders. In 2009, the Department of Mental Health began statewide training and implementation of the *GAIN Short Screener* in efforts to identify and provide better treatment for individuals with co-occurring disorders.
 - Ongoing monitoring of community mental health programs for adults for compliance with minimum standards and the provision of technical assistance as requested by community mental health center regions throughout the state.
 - Enhancing the peer review process by the Division of Consumer and Family Affairs, which has been implementing improvements based on feedback from stakeholders in the peer review process.
 - Increasing coordination of transportation services to address the needs and barriers experienced by individuals served in the public community mental health system and exploring funding opportunities to support piloting of initiatives developed by the Mississippi Coordinated Transportation Coalition.
 - Continuing efforts to develop more housing options for persons with serious mental illness, including identification of the need to dedicate a staff position to address this significant need.
 - Continue working with the Division of Medicaid to develop a proposed State Plan Amendment and/or waiver for submission to the Centers for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community-based services to further support resilience/recovery.

New Developments and Issues

Mississippi Youth Programs Around the Clock (MYPAC)

The Mississippi Division of Medicaid began implementation of MYPAC in October 1, 2007. MYPAC is a demonstration grant from the Centers for Medicare and Medicaid Services (CMS) for a 1915 (c) home and community-based waiver program for youth with serious emotional disturbances. MYPAC provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) for youth still needing the same level of care. Services include Intensive Case Management, Wraparound Services, and Respite Services which are implemented by one of the two providers, Youth Villages or Mississippi Children's Home Society.

As described in more detail in Sections II and III (Adult Services Plan) that follow, the Department of Mental Health, in collaboration with the MS Division of Medicaid, completed a Real Choice Systems Change project, funded by the Centers for Medicare and Medicaid Services (CMS) to pilot a person-directed planning process. Targeted in the project were individuals most at risk for hospitalization or rehospitalization, such as individuals with co-occurring mental illness and substance abuse disorders, as well as adolescents and young adults in transition from child to adult service systems. Inherent in implementation of the person-centered planning process is a shift in philosophy to more individualized, person-driven services. The Department of Mental Health collaborated with the MS Division of Medicaid to implement a Rebalancing Initiative funded by CMS to address transportation planning; CMS funding for the project ended in September 2008. The goal of this project was to coordinate statewide planning for transportation services for individuals with disabilities by working with state and local transportation services providers to offer an array of transportation services. The Mississippi Coordinated Transportation Workgroup continued to meet monthly in FY 2009 to explore funding opportunities and needs for legislation to pilot efforts developed during the planning grant period.

Policy Academy on Juvenile Justice

Adolescent case review “A” teams, which are designed to divert youth in the juvenile justice system with mental health and/or substance abuse disorders to services and supports in the community, have been developed in the seven regions directed by the Mississippi Department of Human Services. Training for these A teams to function appropriately was developed and provided through a partnership between the Department of Mental Health and the Department of Human Services. Beginning in January 2007, the teams began operating and are available statewide. Additionally, those community-based Adolescent Offender Programs serve youth in juvenile justice who require community mental health treatment through day treatment and other programs, as appropriate, which are available through the regional community mental health centers.

Disaster Planning Update

Post- Hurricane Katrina, the MS Department of Mental Health established the Division of Disaster Preparedness and Response. The director and five part-time State Disaster Mental Health Coordinators make up this division. The Division of Disaster Preparedness and Response is responsible for the development of a disaster behavioral health response system and the development and maintenance of the DMH’s Statewide Disaster Response Plan. Additionally, this division is responsible for carrying out the responsibilities as assigned to the MS Department of Mental Health in Mississippi’s Comprehensive Emergency Management Plan. In the event of a disaster declared by the President, the Division of Disaster Preparedness and Response is responsible for the establishment and oversight of the FEMA funded crisis counseling program in the affected areas. Should additional assistance be needed, the Division of Disaster Preparedness and Response has the capacity to activate 18 additional disaster behavioral health team

members to assist with response. DMH has developed an internal behavioral health incident command system. All of the members of DMH's Disaster Behavioral Health Team have completed training on their respective roles in the event that the incident command system is activated.

The Division of Disaster Preparedness and Response participates in interagency planning and preparedness activities. The division participates in exercises and drills conducted by the Mississippi Emergency Management Agency and the Mississippi State Department of Health. The division has provided technical assistance and training on disaster behavioral health and Psychological First Aid to the staff of the Mississippi Emergency Management Agency and local emergency management agencies. The Division has partnered with the Mississippi State Department of Health to increase the mental health capacity in the state's Volunteers in Preparedness Registry (VIPR) and to provide training to volunteers in Psychological First Aid. Additionally, the Director of the Division of Disaster Preparedness and Response is a member of the Mississippi State Department of Health's Strategic National Stockpile Advisory Committee and has partnered with the Centers for Disease Control's Disaster Surveillance Workgroup to examine mental health surveillance post-disaster. The Division is also an invited member of the At-Risk Populations Planning Workgroup for the Mississippi State Department of Health.

Recognizing the traumatic effects disasters have on individuals and communities, the Division of Disaster Preparedness and Response has partnered with two National Child Traumatic Stress Network sites in Mississippi to promote the provision of trauma-informed care in the public mental health system. Specifically, the Division has participated in planning and implementation of the Trauma-Focused Cognitive Behavioral Therapy Learning Collaboratives, the first Psychological First Aid Learning Community, and the Psychological First Aid Trainer Track of the Learning Community.

Additional Katrina-Related Activities

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

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

Awareness

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

Training

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

Prevention

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

During FY 2009, the Mississippi Hurricane Katrina-Related Youth Suicide Prevention and Early Intervention Project accomplished the following milestones:

- The first youth suicide prevention public awareness campaign was launched. The campaign was entitled *Shatter the Silence* to encourage Mississippians to shatter the silence associated with suicide and seeking mental health care. Goals of the campaign were to raise the awareness of the issue of youth suicide and its prevention and to increase help-seeking behaviors in youth, young adults and caregivers.
- The project partnered with Catholic Charities, Inc., a National Child Traumatic Stress Network site, to initiate and sustain the fourth Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative for mental health clinicians from four community mental health centers and one psychiatric residential treatment facility.
- The project partnered with local MAP teams to conduct a community needs assessment to identify risk and protective factors associated with youth suicide in the respective areas served by the MAP Teams.
- Senate Bill 2770, requiring suicide prevention training for licensed teachers and principals, was signed into law.

As of May 2009, over 530 gatekeepers had been trained by the Mississippi Hurricane Katrina-Related Youth Suicide Prevention and Early Intervention Project. Evidence-based and best practice prevention curricula have been implemented, involving more than 4800 students as a result of training received through the project. An additional 4000 individuals have received youth suicide prevention information through awareness presentations conducted by project staff.

Legislative Initiatives and Changes

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

The Mental Health Reform Act of 1997, often referred to as Senate Bill, 2100, was passed during the 1997 Session of the Mississippi Legislature and continues to impact the

public community mental health system. This significant piece of legislation resulted from several months of study of mental health services in the state by a special subcommittee of the Mississippi Senate Appropriations Committee and was supported by major mental health advocacy groups and the MS Department of Mental Health. Some major areas addressed by the Mental Health Reform Act include: further codification of the Department of Mental Health's authority to set and enforce minimum standards for community mental health services and to ensure uniformity in availability and quality of basic services for adults and children across the 15 mental health regions in the state; establishment of state-operated crisis centers; and, further development in the administration and provision of care to improve the quality of community mental health services. The Department of Mental Health has continued processes for implementation of the provisions of the Mental Health Reform Act of 1997 as resources have become available, including family members, consumers, and service providers in review of policies and procedures related to these efforts. The establishment of the DMH Office of Constituency Services, construction of a network of state-operated crisis centers, and implementation of comprehensive revisions to the *MS Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services*, which are described in Section III that follows, are all initiatives undertaken to implement provisions in the Mental Health Reform Act.

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

House Bill 1275, passed in 2001, authorized the establishment of an Interagency Coordinating Council for Children and Youth (ICCCY), on which the heads of the state agencies for education, health, human services, mental health, rehabilitation services, Medicaid, and the family organization, MS Families As Allies for Children's Mental Health, Inc., continue to participate. The act further established a mid-level Interagency System of Care Council (ISCC) to perform certain functions and advise the ICCCY and to establish a statewide system of local multi-agency (MAP) teams. Senate Bill 2991, passed in 2005 and approved by the Governor, extended the legislation authorizing the ICCCY until 2010 (for another five years).

Senate Bill 2894, passed in 2005, calls for the establishment and phasing in of "A" (Adolescent) teams ~~are~~ modeled after MAP teams (described in detail in the State Plan under Criteria #1 and #3). The "A" teams will address System of Care services for nonviolent youthful offenders who have serious behavioral or emotional disorders and will include, at a minimum, a school counselor, a community mental health professional, a social services/child welfare professional, a youth court counselor, and a parent who had a child in the juvenile justice system who committed a nonviolent offense. The legislation also includes provisions for emergency medical and mental health screening of youth admitted to juvenile detention centers and if necessary, timely referral for further

evaluation and/or treatment. The Division of Children and Youth Services has continued to work collaboratively with the Mississippi Department of Human Services Division of Youth Services to assist and support efforts to comply with this legislation related to development of “A” teams.

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

House Bill 897, which passed during the 2009 Regular Session, which calls for the establishment of a Joint Legislative Study Committee and allows for the formation of an advisory council to that study committee. The committee is charged with studying and making recommendations for improving the mental health system and with making recommendations to the Legislature, including any recommended legislation, by December 1, 2009.

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

Description of Regional Resources

As mentioned previously, the network of services comprising the public mental health service system in Mississippi includes three major service delivery components: regional community mental health/mental retardation centers, state-operated facilities, and other nonprofit service agencies/organizations.

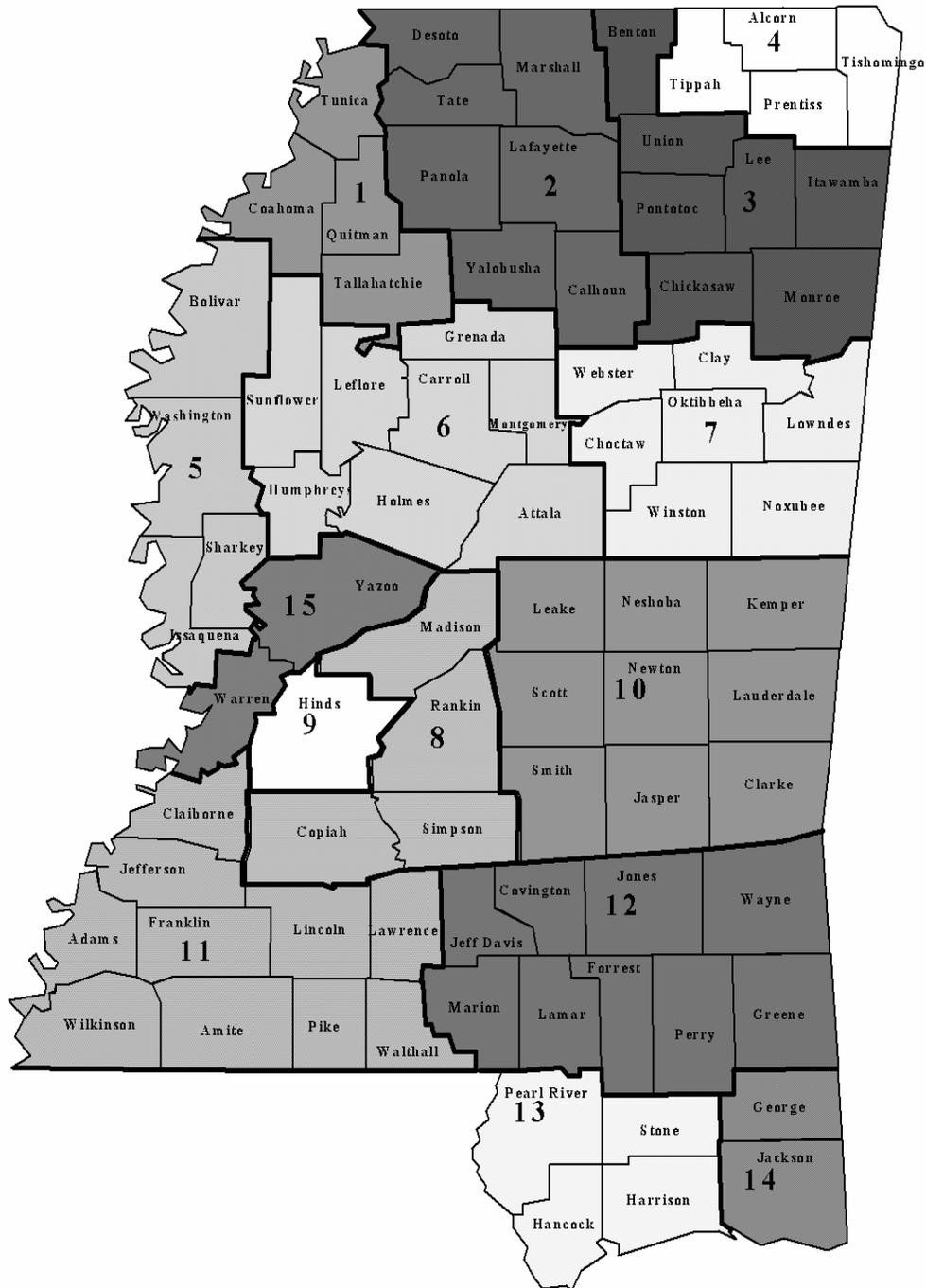
Regional community mental health/mental retardation centers operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 15 regional centers make available a range of community-based mental health services, as well as substance abuse and intellectual/developmental disabilities services to all 82 counties in Mississippi. (See maps and list of community mental health centers on the next pages.) The Regional Commission Act, passed in 1966 and amended in 1972, 1974, and 1997, provides the structure for this community program development by authorizing counties to join together and form multi-county regional commissions on mental health and mental retardation, to plan and implement services in their respective areas. The governing authorities are considered regional and not state-level entities. The Mississippi Department of Mental Health is responsible for certifying, monitoring, and assisting the

regional community mental health centers. These regional community mental health centers are the primary service providers with whom the Department of Mental Health contracts to provide community-based services. In addition to state and federal funds, these centers receive county tax funds and generate funds through sliding fees for services, third party payments, including Medicaid, grants from other agencies such as the United Way, service contracts, and donations.

Generally, community mental health centers have the first option to contract to provide mental health services within their regions when funds are available. The same regional commission legislation that provides for the structure of the community-based regional (multi-county) commissions also authorized participating counties to levy up to two mills tax for programs designed by the regional commission. As a result of this, county tax money preceded state money in the community mental health programs throughout the state. Rather than assess a specific tax, however, counties now make contributions for mental health services from their general tax assessment. The Department of Mental Health is prohibited from funding services at any regional community mental health center that does not receive a specified minimum level of support from each county in the region. That minimum level is the greater of (1) the proceeds of a $\frac{3}{4}$ mill tax in 1982 or (2) the actual contribution made in 1984.

All counties were in compliance with this provision for 2008; the total received from all counties is approximately 3% of total community mental health center receipts. During the last few years, the community mental health centers have made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers.

Community Mental Health/Mental Retardation Center Service Areas



MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH/MENTAL RETARDATION 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, DeSoto, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Michael D. Roberts, 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	Timber Hills Mental Health Services Charlie D. Spearman, Sr., Executive Director 303 N. Madison St. P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 5: Bolivar, Issaquena, Sharkey, Washington	Delta Community Mental Health Services Doug Cole Ph.D., Interim 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 Old 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 302 North Jackson Street P. O. Box 1188 Starkville, MS 39760-1188 (662) 323-9261

Region 8: Copiah, Madison, Rankin, Simpson	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, Director P.O. Box 777, 3450 Highway 80 West Jackson, 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 4378 Meridian, MS 39304 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, 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 1030 Hattiesburg, MS 39403 (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

State-operated facilities include two comprehensive state psychiatric facilities, two small (50-bed) acute psychiatric facilities for adults, a specialized treatment program for adults with long-term, serious mental illness (CMRC), seven crisis centers and five regional centers for persons with developmental disabilities. Additionally, the Department operates one specialized treatment facility for youth with mental retardation whose behavior makes it necessary for them to receive specialized treatment and a similar facility for youth with emotional disturbances. These facilities serve designated counties or service areas in the state and provide inpatient psychiatric, chemical dependence, forensic, and limited medical/surgical hospital services, some community mental health services in areas near the state psychiatric hospitals, intermediate care facility services for persons with mental retardation, and a range of community services for persons with developmental disabilities.

Public inpatient services for individuals with mental illness and/or alcohol/drug abuse service needs are provided through two comprehensive regional psychiatric facilities and two small, adult acute care facilities operated by the DMH through the Bureau of Mental Health: Mississippi State Hospital in Whitfield, East Mississippi State Hospital in Meridian, North MS State Hospital in Tupelo, and South MS State Hospital in Purvis, respectively. Mississippi State Hospital and East Mississippi State Hospital also operate some community-based mental health services for individuals near the hospitals. These include community-based housing options (such as group homes or supervised apartments), case management, clubhouse rehabilitation programs, and special programs for homeless individuals with mental illness. Nursing facility services are also located on the grounds of MSH and EMSH.

As noted in the State Plan, the DMH further regionalized acute psychiatric inpatient and crisis center services to provide more immediate access to emergency services closer to individuals' home communities and families. The 1999 State Legislature authorized construction of seven community-based crisis centers, which are located in Corinth, Newton, Grenada, Laurel, Cleveland, Batesville and Brookhaven.

The Central Mississippi Residential Center (CMRC) is located in Newton, where the former Clarke College property was renovated to allow provision of a specialized treatment program for adults with long-term, serious mental illness. CMRC provides inpatient psychiatric, as well as community services, which include four, 12-bed group homes and *Footprints*, a day program for persons with Alzheimer's disease/other dementia. The Specialized Treatment Facility for Emotionally Disturbed Youth, a 48-bed facility in Harrison County, is designed for youth with mental illness whose behavior makes it necessary for them to receive specialized treatment.

Other nonprofit service agencies/organizations, which make up the smallest part of the service system, may also receive funding through the Department of Mental Health to provide community-based services. Many of these nonprofit corporations may also receive additional funding from other sources, such as grants from other state services agencies, community service agencies, donations, etc. Programs currently provided through these nonprofit agencies include programs for children with emotional

disturbances, community-based alcohol/drug abuse services, and community services for persons with mental retardation/developmental disabilities.

Description of State Mental Health Agency's Leadership

As noted previously, the MS Department of Mental Health is charged statutorily to administer public mental health services in the state. The DMH provides leadership in coordinating mental health services within the broader system, both within its organizational structure and in its relationships with other agencies. For example:

- The Mississippi Department of Mental Health is an independent agency, governed by a state board authority and has responsibility for a range of services for individuals with disabilities and their families, including mental health, intellectual/developmental disabilities, and substance abuse service, as well as for caregiver training and public day programs for persons with Alzheimer's Disease and other dementia. This administrative structure allows for leadership and better coordination of services, particularly for individuals with multiple disabilities.
- By state statute, the Executive Director of the MS Department of Mental Health, serves on the governing board of the MS Department of Rehabilitation Services, which facilitates additional collaboration and coordination of vocational rehabilitation services and activities with the services provided through DMH.
- The MS DMH routinely includes representatives of other agencies that provide direct/support services to individuals with mental illness on advisory councils/task forces (such as the Department of Rehabilitation Services, the Department of Human Services, the Division of Medicaid, the State Department of Education, etc.) and similarly, assigns its staff to serve on committees/councils established by other agencies, as requested.
- The MS DMH works cooperatively with other agencies to implement federal programs administered by agencies that have a broader mission. Some examples include: working with MS Division of Medicaid to monitor/certify community mental health centers participating in the Medicaid Community Mental Health Services Program; working cooperatively with the Division of Medicaid, which is implementing a Community-based Alternatives Psychiatric Residential Treatment Facilities (PRTF) program for eligible youth with a serious emotional disturbance, one of 10 PRTF Demonstration Projects approved by the federal Centers for Medicare and Medicaid Services (CMS); and, working with the Department of Human Services (DHS) by monitoring and certifying community providers receiving funds from DHS for therapeutic foster care, Adolescent Offender Programs with a day treatment component, and therapeutic group home services.
- The Department of Mental Health's Executive Director or designee also serves on other interagency committees designed to address overall health, disability and/or

social services concerns, such as the Disabilities Resources Commission, the Interagency Council for Children and Youth, the Children's Trust Fund and the Pregnancy Risk Assessment Monitoring System (PRAMS).

- The MS DMH established and continues to provide flexible funding for a State-level Interagency Case Review Team for children with SED and for local Making A Plan (MAP) teams (described in the Plan), which address needs of youth with serious emotional disturbances with complex problems that typically involve multiple state agencies.
- The Executive Director of DMH and Director of DMH Division of Children's Services served as chairpersons of the Executive Level Interagency Coordinating Council for Children and Youth (ICCCY) and its mid-management team, respectively, during the first year of operation and in the current year of this legislatively-established interagency entity; both continued participation as members once their one-year terms as chairpersons expired.

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities for FY 2010

Service System's Strengths and Weaknesses

Strengths: Children's Services

- A shared vision and partnership with families of children with serious emotional disturbances have strengthened all of DMH's efforts to build and improve the system of care in the state. Family members have continued to actively participate on the MS State Mental Health Planning and Advisory Council and its Children's Services Task Force since the late 1980's. They also have played a key role in collaborative work with other child and family service agencies, such as serving on the Interagency Coordinating Council for Children and Youth (ICCCY), described in more detail under Criterion 3 in the State Plan.
- 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. For example, 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. Training initiatives focus on staying informed of national mental health service system improvement trends and best practices, in order to transfer this information to impact provision of services at the local level.
- Efforts continued to address the needs of youth in the juvenile justice system with mental health and/or substance abuse disorders and to improve access to appropriate mental health and/or substance abuse treatment services and supports.
- 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 maintains an accessible, structured system for reporting and resolving of grievances and problems in programs certified by the agency, as well as for providing information on statewide service availability, through its Office of Constituency Services (OCS). The OCS maintains a 24-hour, toll-free assistance line, as described in more detail in Section III in both the Children’s Services and Adult Services Plans.
- Efforts to increase and expand youth suicide prevention activities continued, including quarterly meetings of the Youth Suicide Prevention Advisory Council, implementation of the “Shatter the Silence” Campaign, training for service providers on ASIST and safeTALK, collaboration with local school districts in disseminating information on suicide prevention, and the coordination of workshops and conferences on topics related to youth suicide prevention.

Weaknesses: Children’s Services

- 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.
- Development of a more focused strategy to identify and address the needs of children with co-occurring disorders in a more comprehensive way must be

continued by expanding existing effective services and creating new approaches that facilitate prevention and early intervention.

- Work to identify strategies that increase the responsiveness of the system in preparing youth and their families for transition to adulthood must continue.
- 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.
- The need to increase respite services and family education/support services for those families and caregivers who undergo the constant strain of caring for youth with SED are needed to keep children/youth from being inappropriately placed in residential care.

Strengths: Adult Services

- 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. DMH has continued efforts to improve the clubhouse programs by providing technical assistance on the International Center for Clubhouse Development (ICCD) programs model; ICCD-certified programs have been developed that can serve as more cost-effective in-state training sites. The DMH Division of Community Services plans to expand the ICCD certified clubhouses to each region in the state.
- 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, such as elderly psychosocial rehabilitation services and day support. An elderly psychosocial rehabilitation training site was continued in Region 15 (Warren-Yazoo Mental Health Services), and another training site was added in Region 12 (Pinebelt Mental Healthcare Resources) in FY 2009. DMH-certified programs have begun providing psychosocial rehabilitation programs in nursing home facilities. Currently, there are 31 programs in nursing home facilities and continued expansion is projected; an additional nursing home training site has been developed and started in Region 6.
- 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, given interaction with local courts around civil commitment, the fact that 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 Department of Mental Health plans to develop transitional group homes in the northern and central parts of Mississippi for individuals with mental illness and mental retardation who have been frequent users of the justice system and the state psychiatric hospital system.

- 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 continued operation of three intensive residential treatment programs by community mental health centers and through the operation of seven new crisis centers. Total capacity of all the centers will more adequately address a major unmet need for access to crisis intervention and stabilization services on a statewide basis.
- The DMH Division of Community Services and the DMH Bureau of Alcohol and Drug Abuse Services have 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. DMH has developed a more specific strategic plan to address statewide implementation of an integrated service model. A coordinating committee has been developed to address statewide implementation of the Strategic Plan for Services for Individuals with Co-occurring Disorders, the purpose of which is to facilitate implementation of an evidence-based, integrated services model. In FY 2007, DMH was approved to receive additional follow-up technical assistance from SAMHSA's Co-occurring Disorders Center of Excellence (COCE), which has supported work on this issue to date. In 2009, the DMH Division of Community Services initiated statewide training on the evidence-based practice of integrated treatment to ensure that services for individuals with co-occurring disorders of mental illness and substance abuse are uniform, including training and implementation of the *GAIN Short Screener* within its service system. The *GAIN Short Screener* is administered to all adults entering the community mental health system to screen for the need for further assessment of co-occurring disorders of mental illness and substance abuse. DMH will continue its efforts to identify and provide integrated treatment for individuals with co-occurring disorders.
- The perspectives of individuals receiving services and families have long been important in planning, implementing and evaluating the adult service system, contributed through their involvement in numerous task forces, the peer review process and more recently, through provider education and the person-directed planning process. The Division of Consumer and Family Affairs 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 in FY 2010.

- The DMH maintains an accessible, structured system for reporting and resolving of grievances and problems in programs certified by the agency (both formally and informally), as well as for providing information on statewide service availability, through its Office of Constituency Services (OCS). OCS maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. The OCS has also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran. The OCS maintains a 24-hour, toll-free assistance line, as described in more detail in Section III. in both the Children's Services and Adult Services Plans.
- The DMH Division of Community Services has continued to work closely with other agencies, such as the Division of Medicaid, to plan and implement system changes. The Real Choice Systems Change Project, which piloted a person-directed planning process, is an example of how such collaboration can affect system transformation. Efforts will continue to disseminate sustainable components of the person-directed planning project to other areas of the state, such as through case management orientation and other training opportunities. DMH continues to work closely with the Division of Medicaid, as well as other state agencies and local transportation providers, to coordinate statewide transportation planning. DMH continues to serve as a member of the Mississippi Coordinated Transportation Workgroup that meets monthly to address transportation issues and solutions.
- 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.
- DMH has continued to emphasize the importance of the role of case management in the adult service system and provides case management orientation for local service providers on an ongoing basis throughout the year. A Case Management Task Force has maintained its focus on improving case management services, including linkage with other types of support services. Also as mentioned, the DMH has completed work on development of a Case Management Certification Program for individuals working in the public mental health system. In 2009,

DMH included a person-centered planning training component in each of the required DMH Case Management Orientation sessions.

- DMH has continued efforts to develop the Peer Specialist program to enhance employment opportunities to individuals with serious mental illness. Individuals with mental illness have been employed by the DMH to support the peer review process and consumer educational events, as well as to facilitate planning and development of a peer specialist program and employment opportunities. In FY 2008, consumers employed by DMH in the new Division of Consumer and Family Affairs completed Certified Peer Specialist Training in Kansas. Staff from the Division, as well as local provider and NAMI-MS representatives visited peer support programs in Georgia and received technical assistance on program development from certified peer specialists, Medicaid representatives, and Georgia Department of Mental Health staff. Activities to develop peer specialist services continued in FY 2009. The first class of interested consumers received training in the provision of peer specialist services, based on the Georgia model in May 2009, and a workshop for providers interested in peer specialist services was provided as part of the 2009 Mental Health Community Conference. The Bureau of Community Services will also continue efforts to obtain funding support to provide peer specialist services.
- As noted under the strengths for children's services, continuity of administration and experience at both the state and local levels among service providers and advocates have facilitated adherence to ideal system model principles and progress in addressing gaps in the system.
- Additionally, as in the implementation of the children's services systems, recognition of and commitment of resources to providing training, including technical assistance and credentialing programs, characterize strategies for quality improvement for all adult services.
- To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year statewide Anti-Stigma Campaign. The first year of the statewide campaign was launched on May 2, 2007, with a press conference in Jackson, MS. The campaign, which is entitled "What a Difference a Friend Makes," was designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems. Because the campaign targets the transitional age range, this transformation objective was included in FY 2008 through FY 2010 in both the Children's Services and Adult Services State Plans. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work

within their area of the state by getting the word out about the campaign, which reached an estimated 1 million individuals in FY 2008. In October 2009, DMH and the statewide Anti-Stigma Committee will launch a campaign specific to Mississippi entitled, "Think Again." The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. It will continue to show young adults how to support their friends who are living with mental health problems.

- In 2009 the DMH Division of Community Services continues work to develop and pilot three AMAP (Adult Make A Plan) Teams. Division of Community Services staff will collaborate with Division of Children and Youth Services staff to receive training on wrap-around services; the Division will also work with the person-directed planning training sites in Regions 12 and 15 to include this approach in AMAP training. DMH will continue to support and expand AMAP efforts across the state.

Weaknesses: Adult Services

- The need for additional transportation options, with more flexible scheduling, continues to be a need across the state for individuals with disabilities, including individuals with serious mental illness. Maximizing transportation resources available across agencies is key to providing individuals with services and supports that enable them to be independent, such as employment and housing. Additional resources are needed to begin implementation of the plan for transportation that is being developed by the Mississippi Coordinated Transportation Coalition. The DMH continues with the Coalition to explore funding opportunities to consistently coordinate transportation planning in the state.
- The need for increased supported and independent employment options for adults with serious mental illness is ongoing.
- Development of a comprehensive strategic plan to expand housing options statewide for persons with serious mental illness is needed to support recovery.
- Case management service options should be reviewed and approaches modified as needed to reflect a more person-directed approach, including changes to facilitate individuals achieving their employment and independent living goals. Such changes will involve changing behaviors of staff to reflect a shift in philosophy to a more person-centered planning model. Although this area continues to be a weakness, the person-centered planning philosophy was incorporated in case management orientation in FY 2008. DMH continues to provide person-centered training in the case management orientation.

- Continuation of law enforcement training to reach additional experienced officers in communities, as well as strategies to address needs of other emergency services personnel is needed. Additional efforts are being made to address this issue through increased education and networking with law enforcement associations.
- The Division of Community Services 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. 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 Crisis Intervention Team (CIT) training of officers in the state.
- Continued focus on improving transition of individuals from state hospitals, back to their home communities is needed, in particular, development of strategies to better target and expand intensive supports, preferably through a team approach. Currently plans are to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.
- As in the children's services systems, increasing the skill-level of community mental health service providers to affect system changes reflected throughout the plan remains a need.
- 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.

Analysis of Unmet Service Needs/Critical Gaps in Current System and Source(s) of Data Used to Identify Them: Children's and Adults' Services

The needs or critical gaps in the service system are reflected in the weaknesses listed in the previous section, as well as in the summary of areas needing particular attention described in Section I. Data and other information used to identify unmet needs/critical gaps in the service system are obtained from a variety of sources and processes. As mentioned, the Ideal System Models for a comprehensive service system for both children and adults describe service components that must be in place and accessible on a statewide basis in order for the vision of the system to be realized. Analysis of the status of the availability and accessibility of service components depicted in the Ideal System Models, as well as adherence to underlying principles of family-centered and person-driven approaches, are ongoing.

DMH administrative staff also 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). The staff have also benefited from the perspective and

recommendations provided by professionals from other states on federal mental health block grant monitoring visits, most recently a visit conducted in April, 2007. The report of the visit, which was made by knowledgeable and experienced consultants, serves as another source of information against which goals and objectives are evaluated. Similarly, staff review and consider feedback received through annual external review of the State Plan; a copy of the review report is also provided to the Planning and Advisory Council and the State Board of Mental Health.

As reflected in the State Plan, 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.). 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. DMH's federal data infrastructure grant is being used to support much of this work.

As mentioned, the DMH continues to rely on information gathered on availability and accessibility of specific services, availability and qualifications of staff, and training needs through direct contact made on frequent on-site monitoring visits of community mental health programs. Results of these on-site visits, as well as of peer review visits, are documented through a structured reporting and feedback system that includes required plans of correction that address deficiencies in meeting minimum standards set by DMH. DMH staff make follow-up visits to monitor implementation of approved plans of correction. Such ongoing, regular visits to local programs are key to identifying unmet needs.

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 that focus on critical issues (such as co-occurring disorders, homelessness, children's services and case management. The DMH has also benefited greatly from the continuity of its relationship with the MS State Mental Health Planning and Advisory Council, which reviews the DMH's progress on implementation of state plan objectives, both during and at the end of every year. Major family and consumer advocacy groups continue to be represented on the Planning Council. The Council also established a Long-Range Planning Committee in June 2005 and made it a Standing Committee in August 2009; the committee is charged with making recommendations for further advancing and sustaining community-based services and supports. Beginning in FY 2007, the Consumer Rights Committee of the Council surveyed stakeholders, including participants at the Consumer Conferences, for additional input on issues to focus their work and subsequently made recommendations to the full Council. The DMH is implementing statewide consumer and family (for children) satisfaction surveys as

another means of collecting feedback from individuals served by the system.

As described in more detail in the State Plan (Section III), in 2001, the DMH, other agencies and consumer/family advocacy representatives participated in a process to identify and address ten-year expansion of services needed by individuals with disabilities, including individuals with mental illness. This collaborative effort, which was coordinated by the Division of Medicaid, resulted in development of the Mississippi Access to Care (MAC) Plan, which was submitted to the Legislature in the fall, 2001. In addition to considering estimates of prevalence for the 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; for example, major needs for housing and transportation were identified.

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 the 2nd Comprehensive System of Care Project (commUNITY cares), all of which are described in more detail in the State Plan.

As described in the State Plans for children and adults, the DMH management staff also receive regular reports from the Office of Constituency Services (OCS), which as mentioned, 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.

Priorities and Plans to Address Unmet Needs in FY 2010

a) Children's Mental Health System

Priority: Co-occurring Disorders among Youth

Plans: As described in more detail under Criterion 1 in the Children's Services Plan, the DMH Division of Children and Youth Services has undertaken a concerted planning initiative to develop a more comprehensive, strategic approach to better address the needs of youth with co-occurring disorders of serious emotional disturbance and substance abuse. This initiative is a collaborative effort across the Division of Children and Youth Services, the Bureau of Alcohol and Drug Abuse and the Division of Community Services for adults, to also address the need of youth in transition ages. Results of preliminary efforts to establish and target priority areas are described in detail in the Plan in Section III, such as identification of current evidence-based practices on assessment and treatment and facilitation of cross-training to influence state-level policy development and local service delivery systems. The DMH plans to continue its state

office activities to further develop and implement action steps that were included in a more specific statewide strategic plan developed by state and local representatives with technical assistance from the national Co-occurring Disorders Center for Excellence (funded by SAMHSA). The DMH Division of Children/Youth Services continues to employ a professional staff member with extensive experience in providing prevention and treatment services at a community mental health center. This staff member will work closely with other professionals in the DMH and in other child and family service agencies in activities to facilitate coordination and integration of services, to identify and disseminate best practices and other program improvements to address youth in need of services for alcohol/drug use/misuse.

Priority: Fetal Alcohol Spectrum Disorder

Plans: The Mississippi DMH continued its commitment to providing state-level leadership in providing information about FASD and identifying any potential resources for support of initiatives by designating a staff person in the Division of Children and Youth Services to serve as coordinator of these efforts. The major goal of the initiative is to improve the functioning and quality of life of children and youth and their families by diagnosing those with an FASD and providing intervention based on the diagnosis. This initiative will target children birth to seven years old who are referred to the local community mental health center because the child is exhibiting symptoms of an emotional or behavioral disturbance. The children who are screened and diagnosed as having a FASD diagnosis will receive individualized interventions and treatment based on their strengths and needs. Children referred to the UMMC Child Development Clinic for a FASD diagnostic evaluation and who are diagnosed with FASD will be provided with FASD-specific treatment recommendations by the clinic director and diagnostic team. These recommendations will be incorporated into the child's treatment plan at the CMHC, with local MAP teams being responsible for ensuring that resources are available to carry out the treatment recommendations. This initiative will also serve to further identify those treatments and interventions that are most effective for children with FASD. The Division also plans to continue the annual FASD Symposium begun in 2003.

Priority: Staff Training

Plans: As described throughout the State Plan for Children's Services, particularly under Criteria 3 and 5, the DMH Division of Children and Youth Services plans to continue its emphasis on training to increase the skills of community services providers and to facilitate retention of staff, and therefore, continuity of care. The Division of Children and Youth Services also plans to continue its support and participation in statewide conferences that involve staff from other child and family service agencies, such as the Annual Lookin' to the Future Conference, the Juvenile Justice Conference, the conference of the MS Alliance of School Health (MASH), and the first annual Youth Suicide Prevention Conference.

Priority: Working with Schools

Plans: Initiatives in the State Plan for Children under several criteria have as a component, working, training and/or networking with educational staff, both at the state and local levels. As noted under Criterion 3, the State Department of Education has implemented a system of focused monitoring of schools to identify areas in need of improvement, one of which includes identification of children with emotional disabilities. The DMH plans to continue to require community mental health centers to offer school-based services to local school districts; to provide technical assistance in the provision of school-based services, particularly working with case managers to better identify potential barriers to school attendance that might be addressed through the mental health treatment plan; to work with education staff on local MAP teams, the State –level Interagency Case Review Team and the Interagency Coordinating Council for Children and Youth; and, to encourage and support cross-training efforts across the mental health and education systems, both at the local and state levels. Additionally, the DMH Division of Children and Youth Services plans to continue forging a partnership with school-based primary health care providers, i.e. school nurses, through the MS Alliance for School Health at that organization’s annual conference.

Priority: Improving Crisis Intervention Services

Plans: As noted in the State Plan under Criterion 1, the DMH Division of Children and Youth Services plans to continue funding of five comprehensive crisis intervention programs, as well as five smaller, specialized crisis intervention projects. The DMH plans to continue to track progress and products initiated through the four-year Mississippi Trauma Recovery for Youth (TRY) project, funded by SAMHSA and described under Criterion 5 to develop a community practice center in the state for the implementation, evaluation and dissemination of effective child trauma treatment and services in community settings. As described in the State Plan Catholic Charities in Jackson, MS, which implemented the TRY project, will continue as a member of the National Child Traumatic Stress Network (NCTSN), the goal of which is to improve the quality, effectiveness, provision and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward that goal, learning collaboratives focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) will continue to be developed as funds are available; 11 sites in Mississippi, including the Gulf Coast Mental Health Center, were involved in the initial learning collaborative. Ultimately, the DMH plans to develop a process by which information from this project (such as information about standardized assessments for strengths and resiliency, effective practices and financing) can be used to advance implementation of evidence-based practices for improving crisis intervention projects efforts and facilitating the provision of trauma-informed services statewide.

Priority: Housing Supports for Families

Plans: In FY 2009, the DMH continued to work with the MAP teams to focus planning on increasing housing supports for youth with serious emotional disturbances, who may be living at home, but who are nonetheless, at risk for homelessness. Typically, these children have single mothers living at or below the poverty level. The team will continue to focus on transition planning at the inpatient/residential site for institutionalized children to facilitate more stable housing, potentially through other supports, such as education on financial management or adequate supervision of children at home that allows the mother to maintain employment. Additionally, efforts continue to focus on mothers and their children living in a domestic violence program/center and their transitioning back to the community with appropriate housing supports.

Priority: Continued Interagency Collaboration Activities/System of Care

Plans: As described previously and in particular, under Criterion 3 in the State Plan, the DMH and the Division of Children and Youth Services plan to continue interagency activities that facilitate more comprehensive services and supports for youth with serious emotional disturbances and their families. As mentioned, local MAP teams will continue to serve as a point of contact for youth with serious emotional disturbances referred across child and family service agencies. The DMH will continue to provide flexible funding to at least one of these teams in each of the 15 CMHC regions, to increase evaluation of their functioning and to provide additional training to and through the teams. The State-level Interagency Case Review Team will continue to function to address the needs of youth and families that cannot be addressed fully by local MAP teams. Additionally, the Interagency System of Care Council (ISCC) will continue to include a staff member representing the DMH Division of Children and Youth Services, who will also be the primary liaison with local MAP Team Coordinators and the State Level Case Review Team.

Priority: Interagency Efforts with Juvenile Justice

Plans: The DMH Division of Children and Youth Services will continue serving, as requested, on the Juvenile Justice Conference Planning team, which facilitates integration of mental health issues in the conference. Additionally, the DMH Division of Children and Youth Services will provide technical assistance as requested to specialized adolescent “A Teams” formed in FY 2007 and modeled on existing Making A Plan (MAP) teams. These “A” Teams focus solely on the identification and planning of resources for youth in the juvenile justice system who might have serious emotional disturbances (SED).

The DMH plans to continue to provide technical assistance to and monitor Adolescent Offender Programs certified as day treatment programs. The programs (AOPs), as well as other AOPS that are not DMH-certified day treatment programs, are funded by the Department of Human Services and are designed to divert youth from training schools. The DMH will continue to operate a Specialized Treatment Facility for Youth with

Emotional Disturbance to meet the needs of youth whose behavior requires specialized treatment.

Priority: Strategies to Meet the Needs of Youth in Transition

Plans: As described under Criterion 3, the DMH Division of Children and Youth Services plans to continue operation of a Transition Age Task Force, which is chaired by the staff person who is also coordinating the division's work with youth in transitional ages in community-based services. The DMH also plans to continue funding that was redirected to support transitional living programs ~~is~~ operated by the CMHC in Region 12 and by another nonprofit service provider, specifically targeting the needs of youth in transition and facilitating access to a variety of living situations/housing and supports, depending on the needs of the individual youth. These service providers have shared specific strategies with other service providers on the Transition Age Task Force.

b) Adult Mental Health System

Priority: Consumer-directed Activities

Plans: Initiated through the Real Choice Systems Change project on Person-Centered Planning (described in more detail under Criterion 1), the DMH Division of Community Services has continued plans to develop strategies to disseminate a more person-directed assessment and treatment philosophy and approaches. Currently, State funds support further expansion of a person-directed approach to service delivery, focusing initially on case management. Person-centered planning training will be provided at Case Management Task Force meetings and as part of Case Management Orientation. The Division plans to focus on the development of transition planning teams for individuals being discharged from state psychiatric facilities and/or crisis intervention programs. The Division has identified dissemination of a philosophy of more individualized, person-directed assessment and treatment through training and follow-up with professionals and stakeholders involved in the process as key to realization of a recovery-oriented system. Region 12 (Hattiesburg) and Region 15 (Vicksburg) have become PCP training sites and are currently offering training in the PCP process statewide. The Division of Community Services is planning to continue advancement of the person-centered planning philosophy that was added to the case management orientation by seeking additional opportunities for person-centered planning training sites. The Department of Mental Health has established a Division of Consumer and Family Affairs. The objectives of the Division are as follows: (1) To ensure that consumers of mental health services and families of consumers of mental health services are the driving force for improvements in the publicly funded mental health system; (2) To help individuals and their families participate in the decision making at all levels of our public mental health system; and (3) promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services. The Division of Consumer and Family Affairs plans to continue its focus on improving the peer review process to better assess if programs are recovery-oriented. The division also plans to continue supporting consumer education and support programs provided through NAMI-MS (such as Peer to

Peer) and the Mississippi Leadership Academy. The Mississippi Leadership Academy was implemented in 2006, with over 100 participants thus far. Persons who have participated in Peer-to-Peer training, or other state supported educational trainings or who are interested in increasing their leadership skills will be provided an opportunity to participate in the Academy, as resources are available. In FY 2010, the Division of Consumer and Family Affairs will work with other divisions in DMH to make available education and informational materials about recovery and empowerment. The division will also continue its work to develop the peer specialist program, including providing education to the mental health provider system about meaningful roles for peer specialists, as well as to explore the feasibility of training family peer specialists. Additionally, in FY 2010, the Division of Consumer and Family Affairs will continue activities to facilitate the establishment of an independent consumer coalition. For example, the division is planning to develop a retreat for identified consumer leaders at which they can receive expert technical assistance in developing and sustaining a coalition.

Priority: Crisis Services

Plans: As indicated under Criterion 1, the DMH seven state-operated crisis centers were fully operational in FY 2008. Working with community mental health centers and hospitals that serve the same areas as the crisis centers has been a priority in establishment of the centers. The Department of Mental Health has continued to work with the Mississippi Legislature, which authorized the piloting of one state crisis center (in Grenada), shifting its operation by Mississippi State Hospital to operation by a community mental health center during FY 2010. The DMH plans to further expand this model to all crisis center regions within five years. Also in the State Plan for FY 2010 are objectives to continue funding three intensive residential treatment programs operated in Regions 6, 13, and 15 and to continue support of intensive case management services. As described previously, the DMH Division of Community Services plans to continue efforts on developing a structure that more effectively targets intensive supports to individuals being discharged from crisis intervention programs or inpatient psychiatric facilities, such as through development of transition planning teams at the hospitals that work closely with community mental health centers and individuals receiving services and if appropriate, with their families. DMH plans to develop transitional group homes and supervised living options in the north and central part of Mississippi. As mentioned, the Division plans to disseminate person-centered planning training in additional mental health regions in the state.

Priority: Transportation

Plans: As described under the Significant Achievements in FY 2009 for Adults in Section I, the DMH Division of Community Services continued an initiative begun with the Division of Medicaid through a transportation committee that is seeking to maximize funding for and the use of transportation for individuals with disabilities. In general, as conceptualized in preliminary discussions, a coordinated system of transportation that involves more efficient and effective scheduling and dispatching of transportation

resources to prevent duplication is envisioned. Such a system would ultimately provide individuals with more flexible options that are necessary for them to pursue goals of employment and more independent living arrangements in the community. The DMH Division of Community Services implemented a Rebalancing Initiative grant awarded by the federal Center for Medicare and Medicaid Services (CMS) to develop a coordinated system of transportation in two mental health regions of the state: Region 4, located in the northeastern part of the state, and Region 15, located in the west-central part of the state. Planning meetings have continued, and the Mississippi Transportation Coalition was established that includes key stakeholders, including major state agencies that provide and/or support transportation, advocacy groups and individuals receiving services. Following Hurricane Katrina, DMH was awarded a supplemental grant to coordinate transportation in Hancock County (Region 13) on the coast, which was severely impacted by the storm. Since that time, a coalition has been formed in Hancock County, made up of transportation providers and consumers from the Gulf Coast. The goal was to replicate the statewide transportation plan in Hancock County, where services were devastated by Hurricane Katrina. As part of the Coalition's planning work, two grants were funded for two years by the Mississippi Council on Developmental Disabilities to implement some of the recommendations of the Coalition for the statewide transportation system on a test basis. Also, as part of the Coalition's work on the coast, transportation services were set up in Hancock County. CMS funding of the Rebalancing Initiative for coordinated transportation planning ended in September 2008. The Mississippi Transportation Coalition, which includes DMH representatives, continues to meet and seek additional funding avenues to pilot strategies developed by the Coalition to address unmet transportation needs.

Priority: Specialized Services and Supports for Elderly Persons

Plans: As described in more detail in the State Plan under Criterion 1, the DMH Division of Community Services plans to continue to provide technical assistance to community programs that have implemented elderly psychosocial rehabilitation programs. As noted, the DMH committed part of its CMHS Block Grant funds to support a model training site that can serve staff from other sites in-state. Thus far, one training site has been established, and plans are to continue to make training available in north, central and south Mississippi. The Division of Community Services also plans continued collaboration with the Division of Alzheimer's Disease/Other Dementia, which provides specialized training for caregivers. Two training sites have been developed and an additional training site for nursing home programs was developed in Region 6. Expansion of elderly psychosocial rehabilitation programs is anticipated in FY 2010.

Priority: Additional Housing Options

Plans: As described under Criterion 1, the DMH plans to help support and monitor the provision of a range of community living options for individuals with serious mental illness, including transitional residential programs, group homes and supervised housing. As noted in Section I, 48 group home beds, operated by the Central MS Residential Center, will continue to be available in Newton; two additional homes were opened by

East MS State Hospital Division of Community Services in FY 2008. Efforts to develop more housing options for individuals with serious mental illness will continue. DMH plans to develop transitional group homes in the northern and central part of Mississippi for individuals with mental illness and mental retardation who have been frequent users of the justice system and the state psychiatric hospital system. The possibility of dedicating a staff position to address this significant need is under consideration. The Division of Planning in the Bureau of Community Services has been participating in the NASMHPD Housing Task Force and will continue to network with potential partners at the state and local level and to seek specialized technical assistance to facilitate development of a strategic plan for housing.

Priority: Services for Individuals with Co-occurring Disorders

Plans: As described in the State Plan under Criterion 1, the DMH Division of Community Services plans to continue to provide financial support and technical assistance to community mental health centers to implement guidelines for specialized services for individuals with co-occurring disorders. The focus of activities will be on continued training and monitoring to facilitate implementation of a truly integrated system of care for persons with co-occurring disorders of mental illness and substance abuse. Also, as mentioned previously, the DMH plans to continue its state office activities to further develop and implement action steps that were included in a more specific, statewide strategic plan developed by state and local representatives with technical assistance from the national Co-occurring Disorders Center for Excellence (funded by SAMHSA). In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to ensure that uniform services are being provided to individuals with co-occurring disorders of mental illness and substance abuse. In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to facilitate the provision of uniform, evidence-based services to individuals with co-occurring disorders of mental illness and substance abuse. The use of the *GAIN Short Screener* as a standard screening instrument will continue to be required.

Priority: Psychosocial Rehabilitation Programs

The DMH plans to expand ICCD-certified clubhouse programs to a minimum of one per region.

Priority: Training of Law Enforcement/Other Emergency/Health Personnel

Plans: As described in more detail under Criterion 5 in both the Adults' and Children's Services Plans, the DMH plans to maintain the availability of training for law enforcement personnel and monitor the provision of other training provided at the local level to address the needs of other emergency services personnel. An additional initiative related specifically to better assessing and treating trauma among children/youth is also described in the Children's Services Plan. As mentioned, in FY 2009, the Division of Community Services plans to refocus its efforts to reach additional law enforcement personnel. Strategies will include increased collaboration with the Department of Public

Safety and outreach to other emergency services personnel, such as ambulance drivers, first responders, and volunteer fire departments. DMH will continue to explore grants and other funding opportunities to facilitate the provision of Crisis Intervention Team (CIT) training to officers across the state.

Priorities and Plans to Address Needs Across Children's and Adults' Mental Health Systems

Priority: Data Infrastructure Improvements

Plans: As described under Criterion 5 in both the Children's and Adults' Services Plans, the DMH is continuing its efforts to conduct a planning and data mapping process necessary to construct and implement a central data repository for public mental health information management at the DMH Central Office. It is anticipated that this process, which will enable the state to report federal Uniform Reporting System (URS) information, will be continued in FY 2010. The DMH will also continue to implement statewide assessment of satisfaction of adult consumers and families of children with the services they receive through the public community mental health system. Funds from a federal Data Infrastructure Grant (DIG) Quality Improvement project provided by CMHS will continue to be used to support this process, which will ultimately facilitate better availability, quality and integration of process and outcome data needed to support ongoing work of the Planning Council and other quality improvement efforts.

Priority: Continued Involvement of Individuals Receiving Services and Families

Plans: As noted throughout the State Plan, the DMH plans to continue involvement of consumers and family members through numerous task forces, the peer review process, and the MS State Mental Health Planning and Advisory Council. Structured orientation of new Planning Council members will be continued, as well as administrative support of the Council and its committees. As mentioned, the MS State Mental Health Planning and Advisory Council established an ad hoc Long-Range Planning Committee in FY 2005, which includes individuals receiving services and family members, to explore in more depth needs, issues and recommendations for continued development of community-based services and supports. With Council approval, the committee was extended into FY 2009, and a recommendation for extension and expansion of the committee's work to include continuity of care issues will be presented to the full Council. The Consumer Rights Committee and the Children's Services Task Force, both of which include consumers and family members, will also continue their work in FY 2010.

Priority: Cultural Competence

Plans: As described in both the Children's Services and Adults' Services Plans, the DMH plans to continue its commitment to both require and provide training in cultural diversity. The DMH plans to continue operation of the Multicultural Task Force, with continued focus on assisting local providers in assessing the cultural competence of their organizations and to plan to address the results of those assessments. The task force has

also developed a draft model statewide cultural competence plan for the service delivery and organizational levels.

Priority: Training

Plans: The DMH plans to continue its work to implement a training and credentialing program for staff who work in the public mental health system and are not covered by any other credentialing programs. The DMH also plans to continue to implement training and credentialing for public mental health administrators and for case managers. (See Criterion 5.) The DMH plans to continue to work with the University of MS Medical Center (UMC) Department of Psychiatry and Human Behavior to continue implementation and development of cooperative psychiatry training programs at MS State Hospital and in community-based service settings.

Priority: Wrap Around Services

Plans: In 2009 the DMH Division of Community Services will continue work to pilot three AMAP (Adult Make A Plan) Teams in community mental health regions 6, 7, and 8. The programs are in initial stages, developing community partnerships with interested agencies/organizations. The Division will continue funding this effort and will begin exploring funding avenues to expand AMAP services into other CMHC regions. The Division of Community Services for adults will continue to collaborate with the Division of Children and Youth Services, which has implemented Making A Plan (MAP) teams for youth in all 15 regions, to receive training on wrap-around services. The Division of Community Services will work with person-centered planning training sites in Regions 12 (Pine Belt Mental Healthcare Resources) and 15 (Warren-Yazoo Mental Health Services), to address a person-directed philosophy as part of this training for AMAP team development.

Priority: Monitoring of Use of Financial Resources

Plans: The DMH plans to maintain its system of internal fiscal and property auditing within programs it directly operates. The DMH Division of Audit in the Bureau of Administration plans to continue their activities to monitor use of resources by all local providers certified and funded by DMH to assure that the DMH-funded activities of the sub recipients are in compliance with applicable laws, regulations, policies, and procedures.

Summary of Recent Achievements that Reflect Progress toward the Development of a Comprehensive Community-based System of Care

Significant Achievements – Children’s Services:

MAP Teams: County Making a Plan (MAP) teams continued in the state, with representatives from key child and family services agencies at the local level reviewing the needs of children with serious emotional disturbance who were at imminent risk of

inappropriate placement out of home. Coordinators of these MAP teams also have continued to meet on a monthly basis to further identify needs and develop resources in local communities. Thus far, 36 MAP teams have been developed statewide with and without DMH funding. The ultimate goal of this initiative is to expand the availability of these teams for convenient accessibility for children and their families close to their communities and to provide flexible funds up to the amount determined adequate.

Suicide Prevention: In FY 2009, the DMH Division of Disaster Preparedness and Response implemented the third year of a three-year *Hurricane Katrina-Related Youth Suicide Prevention* project, funded through a grant from SAMHSA. The project is focusing on provision of training in identification of youth, ages 10-24 who are at risk for suicide across the six coastal counties of Mississippi that were heavily impacted by Hurricane Katrina. Staff from Region 13 CMHC (Gulf Coast Mental Health Center) have also received training in the evidence-based practice of trauma-focused cognitive behavior therapy (TF-CBT) through the Trauma Recovery for Youth (TRY) project, coordinated by Catholic Charities, Inc. The DMH established a State Youth Suicide Prevention Advisory Council to develop a statewide strategic plan for youth suicide prevention, staffed by the Division of Children and Youth Services, which includes representatives from the MS Department of Health, the MS State Department of Education, from the Jason Foundation (non-profit organization addressing youth suicide prevention), a psychologist from the community and from a local college, the Coordinator of Children's Services at Gulf Coast Mental Health Center (Region 13), and the Project Director of the SAMHSA-funded prevention project described above.

Training: The DMH Division of Children and Youth Services staff continued to provide training and technical assistance at the local level and to co-sponsor or participate in statewide conferences involving other child and family service agencies, including the Mississippi Institute of School Health, Wellness and Safety; the annual Juvenile Justice Symposium; and, the annual "Lookin' to the Future" Conference. Additionally, Division of Children & Youth Services continues to provide technical assistance to the "A" (Adolescent) Teams for youth involved in the juvenile justice system who are court-ordered to programs/services in the community, such as the day treatment model Adolescent Offender Programs (AOPs) for youth with mental health and/or substance abuse disorders. The Mississippi Department of Human Services (DHS) Youth Services Division is the lead agency for forming these new "A" Teams. Also, the Director of the Division of Children and Youth Services continued to work collaboratively with Catholic Charities as a senior advisor on their efforts to implement the SAMHSA-funded Trauma-Recovery for Youth (TRY) project through that collaboration, supported the Project Director at Catholic Charities in implementing the first learning collaborative to train clinicians at Gulf Coast Mental Health Center in trauma-focused cognitive behavior therapy (TF-CBT). DMH continues to provide CMHS Block Grant funding for additional mental health therapists across the state to be trained through the learning collaborative model.

School-based Services: In FY 2009, the DMH Division of Children and Youth Services continued to monitor the implementation of school-based services by CMHCs, including

school-based outpatient and day treatment services. School-based outpatient services were provided by the 15 CMHCs, and school-based day treatment services were provided by 13 of the 15 CMHCs; the DMH is taking appropriate actions to follow up in the regions in which these services were not available. Two CMHCs also continued to utilize therapeutic nurses based in the schools to provide ongoing physical/medical care to children with serious emotional disturbances who receive outpatient mental health services.

State-Level Interagency Collaboration: The State-Level Interagency Case Review Team continued to receive flexible funds to support services for children/youth reviewed by the team and for whom funding and/or other resources were not identified as accessible at the local level, including youth who reside in counties without MAP teams. The Interagency Coordinating Council for Children and Youth (ICCCY), established by state legislation in 2001, has continued operation and was extended by state legislation until 2010. This state-level collaborative team continued in FY 2009 to be a significant part of the overall interagency team structure that includes local MAP Teams in addressing the population defined by the legislation.

In FY 2009, the Interagency System of Care Committee (a mid-level group formed by the ICCCY) continued to review/revise the original 2002 plan for improving and implementing a cross agency system of care for children and youth, which was approved by the State Level ICCCY. The Committee also began an assessment and study with independent contractors to develop continuing legislation in 2010 when Senate Bill 2991 sunsets. The ICCCY includes Executive Directors of the five major public child and/or family service agencies, the Office of the Governor, Division of Medicaid, and MS Families As Allies for Children's Mental Health, Inc. (MS FAA), a statewide family education and family support organization for children's mental health.

Transitional Services: The MS DMH continued funding for two Transitional Outreach Programs (P-TOP) in Region 12 (Pine Belt Mental Health Care Resources) and in Hinds County (MS Children's Home Society), which supports the provision of mental health services needed by youth, ages 16-21 years of age, in a transitional living program

Application for Grants to Advance System Development In FY 2008, a DMH Division of Children/Youth-Services received a SAMHSA funded Fetal Alcohol Spectrum Disorders (FASD)-contract with Northrup Grummond to work through the Community Mental Health Centers and the MAP Teams statewide to screen, diagnose, and treat children with FASD.

In FY 2006, the MS DMH Division of Children and Youth Services was awarded funding from SAMHSA for a second Comprehensive System of Care Project. This project is in its third year of implementation, during which specialized and evidenced based practices are provided to children affected by severe emotional disturbance (SED) and/or co-occurring SED and substance misuse in a region of the state (Forrest, Lamar and Marion counties) that has high need for, but low availability of services; this area can serve as a model for other rural areas. Mississippi Families As Allies for Children's

Mental Health, Inc. (MS FAA) and Pinebelt Mental Healthcare Resources (Region 12 CMHC) are partners with the DMH Division of Children and Youth Services in leadership, staffing, and support of the five-year project, which has been named commUNITYcares (uniting neighborhoods – integrating through youth).

The DMH's application to SAMHSA for funding of a *Hurricane Katrina-Related Youth Suicide Prevention and Early Intervention* proposal was funded, beginning October 1, 2007. The three-year project targets primarily six counties on the Mississippi coast, with dissemination of training components of that effort in Year 3 of the project.

Co-occurring Disorders Among Youth/Young Adults In FY 2005, the DMH received technical assistance from the national Co-Occurring Disorders Center for Excellence (COCE) funded by SAMHSA, as well as follow-up technical assistance in FY 2006 to advance planning efforts that resulted in development of a *Strategic Plan for Co-occurring Disorders* addressing all age groups. In May 2006, the DMH applied to SAMHSA for a competitive Co-Occurring State Incentive Grant (COSIG) to further develop the infrastructure for statewide training and implementation of evidence-based screening, assessment and treatment for individuals with co-occurring disorders; however, that proposal was not funded. As mentioned, the local (Region 12) System of Care project addresses the needs of youth with co-occurring disorders. In FY 2007, DMH has been approved to receive additional follow-up technical assistance from the COCE, to facilitate implementation of its *Strategic Plan for Co-occurring Disorders*. The Division of Children and Youth Services also received consultation to facilitate assisting the Mississippi Department of Human Services (DHS) in providing training about co-occurring disorders for staff in Adolescent Offender Programs (AOPs) and youth court counselors.

Significant Achievements – Adults

Family Education and Support The DMH continues to provide support for the implementation of the Family-to-Family Education Program in Mississippi and anticipates that the number of family members who are trained to hold education classes and to provide support groups will continue to increase.

Consumer Education The DMH continues to provide support for the implementation of NAMI Peer to Peer Program, the Mississippi Leadership Academy and other approved consumer education programs in Mississippi, which includes training of trainers and provision of consumer education classes.

Specialized Programs for Elderly Persons The DMH Division of Community Services continues to provide technical assistance to local community mental health programs that are establishing elderly psychosocial rehabilitation programs, including implementation of a model training program. Efforts have focused on maintaining availability, improving the quality and facilitating further development of psychosocial rehabilitation services for elderly persons, including community-based programs and newly-developed services provided in nursing homes, throughout all service regions of the state. Staff in the DMH

Division of Community Services also continue to collaborate with the DMH Division of Alzheimer's Disease/Other Dementia in planning and hosting what has become an annual conference on Alzheimer's Disease and Psychiatric Disorders in the Elderly. In 2008, the Division of Community Services continued an elderly psychosocial rehabilitation program training site in Region 15 (Warren-Yazoo Mental Health Services) and added an additional training site in Region 12 (Pine Belt Mental Healthcare Resources). In FY 2009, the Division of Community Services continued support of an elderly psychosocial rehabilitation program training site in Region 15 (Warren-Yazoo Mental Health Services) and Region 12 (Pine Belt Mental Healthcare Resources). DMH also added a training site in Region 6 (LifeHelp).

Other Psychosocial Rehabilitative Services The DMH Division of Community Services continues to support technical assistance and training at an International Center for Clubhouse Development (ICCD) model program site in Region 5 (Greenville) to improve the quality of clubhouse psychosocial rehabilitation programs throughout the state. Training has included the transitional employment component of the program. The clubhouse program in Region 6 (Greenwood) also has ICCD certification, and Region 12 CMHC, Pinebelt Mental Healthcare Resources (Oasis Clubhouse), is currently seeking ICCD Certification. DMH plans to expand ICCD-certified clubhouse programs at a minimum of one in each region.

Case Management The DMH continues to provide support for case management services, including intensive case management. Case management orientation also continues to be a requirement for case managers in all regions of the state, and the MS DMH has developed a structured case management credentialing program. DMH has also continued review of minimum standards for mental illness management services (MIMS), individual therapeutic support and intensive case management for needed revisions to enhance person-directed services (person-centered planning). In 2008, person-centered planning was added to the case management orientation provided by the Department of Mental Health. In FY 2009, person-centered planning continued to be included in Case Management Orientation provided by the Department of Mental Health.

Specialized Programs for Persons with Mental Illness who are Homeless The DMH Division of Community Services continued to allocate federal PATH funding to six program sites in Mississippi, based on results of a needs assessment. DMH Division of Community Services staff continue to participate in a workgroup established by the DMH and focusing on the needs of individuals who are homeless; staff are also involved in three additional interagency coalitions addressing homelessness/housing.

Services for Individuals with Co-occurring Disorders of Substance Abuse and Mental Illness The DMH Division of Community Services continues its work through a Co-occurring Disorders Task Force with the DMH Division of Alcohol and Drug Abuse and the Division of Children and Youth Services in supporting the provision of specialized services and staff training in the area of co-occurring disorders of serious mental illness and substance abuse. In FY 2005, the DMH received technical assistance from the national Co-Occurring Disorders Center for Excellence (COCE) funded by SAMHSA, as

well as follow-up technical assistance in FY 2006 to advance planning efforts, which resulted in development of a *Strategic Plan for Co-occurring Disorders* addressing all age groups. In May 2006, the DMH applied to SAMHSA for a competitive Co-Occurring State Incentive Grant (COSIG) to further develop the infrastructure for statewide training and implementation of evidence-based screening, assessment and treatment for individuals with co-occurring disorders; however, that proposal was not funded. In FY 2007, DMH was approved to receive additional follow-up technical assistance from the COCE, to facilitate implementation of its *Strategic Plan for Co-occurring Disorders*. The Division of Children and Youth Services also received consultation to facilitate assisting the Mississippi Department of Human Services (DHS) in providing training about co-occurring disorders for staff in Adolescent Offender Programs (AOPs).

Continued Monitoring of Programs and Peer Review The DMH Division of Community Services continues its work to regularly conduct on-site visits of programs to monitor for compliance with minimum standards for community mental health services, a comprehensive review of which is currently underway. The DMH also continues to support a peer review process that includes family members, consumers, and service providers in on-site visits to community mental health services programs. Changes to the peer review process have been phased in, which will result in more consumers being included on the peer review team.

Person-Centered Planning Initiatives

In 2009, the DMH Division of Community Services piloted three AMAP (Adult Making a Plan) Teams in community mental health regions 6, 7, and 8. The Division of Community Services for Adults will collaborate with the Division of Children and Youth Services, which has implemented Making A Plan (MAP) teams for youth in all 15 regions, to receive training on wrap-around services. The Division of Community Services will work with person-centered planning training sites in Regions 12 (Pine Belt Mental Healthcare Resources) and 15 (Warren-Yazoo Mental Health Services) to address a person-directed philosophy as part of this training for AMAP team development.

State's Vision for the Future

The Ideal System Models described under Criterion 1 in Section III in both the Adult Services and Children's Services sections of the State Plan reflect the comprehensive community-based public mental health system envisioned by the state and have guided the development of goals and objectives in the State Plan over time. As noted in Section III, the models communicate the vision and values underlying system development and improvements, as well as the service components of the ideal systems for children with serious emotional disturbances and adults with serious mental illness. The State Plan also reflects the elements of the vision as set forth in the Mississippi Board of Mental Health's and the Mississippi Department of Mental Health's overall *Strategic Plan, FY 2010-2020*, which was approved by the Board in June 2009: equal access to quality mental health care, services and supports in the community; active participation by consumers in

designing services; elimination of stigma; and enhancement of prevention, care, services and supports through the application of research, outcome measures and technology. The current *draft FY 2010 State Plan for Community Mental Health Services* will undergo additional review for alignment with the recently approved *Strategic Plan, FY 2010-2020*.

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

(a) FY 2010 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

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

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

Ideal System Model

The development of children's mental health services in Mississippi was established as a priority of the Department of Mental Health in 1980, through the State Board of Mental Health's creation of a Division of Children and Youth Services within the Bureau of Mental Health. The Department and the MS State Mental Health Planning and Advisory Council also decided in initial stages of planning to develop a separate comprehensive plan for community-based services for children, similar in organization and approach to the adult services plan, but specifically addressing the unique needs of children and families. They also developed an Ideal System Model for the Mississippi Comprehensive Community Mental Health System for Children with Serious Emotional Disturbance (see Figure that follows), upon which long-term goals were based. Realistic annual objectives have been formulated to address gaps in the system, given available human and fiscal resources, while efforts to sustain and increase resources have been ongoing. All goals and objectives continue to represent ongoing efforts to develop a comprehensive system of care for children represented by the Ideal System Model for community-based services. The time line for all objectives in the FY 2010 plan for children is October 1, 2009 through September 30, 2010.

The Ideal System Model for the Mississippi Comprehensive Community Mental Health System for Children with Serious Emotional Disturbance communicates the state's vision for a statewide, child- and family-centered system of care, which emphasizes the importance of access and coordination with other child and family service agencies. An array of community-based services, including a variety of outpatient, day and community residential mental health service options encircle the child and the family in the Ideal System Model. Key to access and coordination, as reflected in the model, is case management, which has been a focus of expansion of children's mental health services. Since the Ideal System Model is community-based, built on the belief that children and families should be served as close to their homes and natural support systems as possible, therapeutic support services and advocacy systems are key among the service components of the ideal system. Thus, the system recognizes the critical importance and expertise of parents in identifying and meeting the needs of children with serious emotional disturbance and the value of facilitating the development of family education, support and

advocacy networks.

System-wide support services may include services for which agencies or entities other than the state mental health agency are the primary providers, such as educational services, medical services, dental services, financial assistance or certain social services. The Ideal System Model for children's mental health services described in this plan is based on a broader vision of an interagency network of services or system of care, in which the mental health system interacts with the other child and family service systems. In this ideal system of care, the focus should be on the functioning of each of the systems in the network to meet individualized needs of the child and family, thus making them all child- and family-centered. For example, the provision of individualized services to youth in therapeutic group homes could involve the mental health, social services, health services and educational services components of the system of care. System-wide support services may also include some operational services that may be provided through a variety of other agencies or entities, such as transportation or volunteer services. (Stroul and Friedman, 1986).

Services for Youth with Co-occurring Disorders (substance abuse and mental illness)

System-wide support services now include substance abuse services, which in Mississippi, are administered by the Department of Mental Health. As indicated later under this Criterion, substance abuse services currently available for youth include prevention services, outpatient services (general and intensive), primary residential treatment for adolescents (through three programs), outreach and aftercare and inpatient services. The inclusion of substance abuse services as a system-wide support emphasizes the Division of Children and Youth Services' intent to expand and strengthen linkages that make substance abuse services more accessible and responsive to the needs of youth who also have a serious emotional disturbance.

The underlying principles of a child- and family-centered system that allows access to an array of community-based options, coordinated through case management, have remained stable over time. The mental health and support system components of the system are more likely to change as the needs and strengths of children and families change. Inherent in the Ideal System Model are the characteristics of consistency, based on service philosophy and values, and flexibility, to allow for responsiveness to changing needs and service environments.

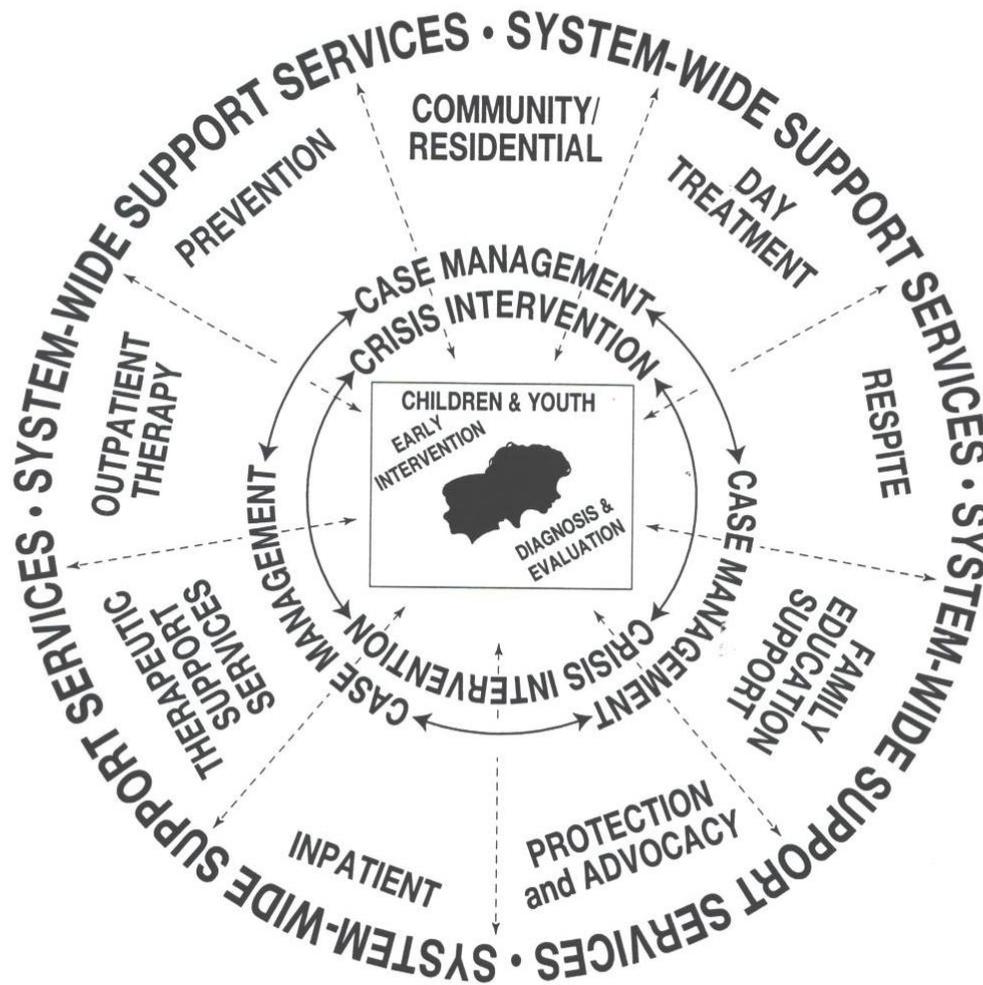
The major service components of the Ideal System Model For Children include: prevention, early intervention, diagnosis and evaluation, case management (school-based case management, individual therapeutic support, and mental illness management services), crisis intervention, outpatient services, day treatment, respite services, community-based residential services, protection and advocacy, family education and support, inpatient services, other support services, and system-wide support services. Based on recommendations of the Children's Services Task Force and the Planning Council, prevention, family education/support, and crisis intervention are depicted as distinct major service components in the model, beginning in FY 1998, reflecting their relative importance in the service system.

Efforts to enhance interagency collaboration, including operation of a State Level Interagency Case Review/MAP team, local interagency MAP (Making a Plan) teams, and in more recent years, the Interagency Coordinating Council for Children and Youth (ICCCY), are described in

this Plan under Criterion #3 and reflect the establishment of structures that build on families' strengths while addressing the special needs and circumstances of children. The Plan also describes continued efforts to increase the availability, accessibility and quality of children's services across the 15 community mental health regions.

IDEAL SYSTEM MODEL

Mississippi Comprehensive Community Mental Health System
for
Children With Serious Emotional Disturbance



CHARACTERISTICS OF THE SYSTEM

- Child and Family-Centered
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- System is Community-Based
- Emphasizes Both Service Availability and Advocacy and Support Networks

Organizational Structure and Development of the Comprehensive System of Care

As described in more detail in the Section I, the Mississippi Department of Mental Health sets and monitors implementation of minimum 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, management and in specific services, is monitored through on-site visits of programs throughout the year by DMH staff.

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through 15 regional mental health/mental retardation commissions, which operate 15 regional community mental health centers serving all 82 counties of the state. 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 community mental health centers began providing outpatient services to children and adolescents with serious emotional disturbance as Medicaid reimbursable services in 1986. Prior to 1990, Medicaid reimbursable outpatient services for children and youth with SED provided through the CMHCs included only individual, group and family therapy. Since adding day treatment and case management as Medicaid reimbursable services in 1990, the community mental health system has grown to serving 29,269 children/youth with SED in FY 2008.

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) 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, 45 visits per year.

The Children's Health Insurance Program (CHIP) described under Criterion 3 also includes inpatient and some outpatient mental health services, as well as substance abuse services from approved providers, within specified limits. Mental health services include: outpatient care, not to exceed 52 visits per member/benefit period; partial hospitalization, not to exceed 60 days per member/benefit period, and inpatient care, not to exceed 30 days per member/benefit period.) Precertification/prior authorization for inpatient care and partial hospitalization by network provider is required.

Federal and State Resources

The FY 2010 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2009 Session. Also included under Criterion #5 in the Children's Plan and in the Adult Plan are objectives to request additional state funds for the 2011 fiscal year. Changes indicated under this criterion also reflect changes to the CMHS Block Grant

received to date, including a decrease to the FY 2009 state allocation. The Department of Mental Health (DMH) administers and grants to local providers funding from the federal Community Mental Health Services (CMHS) block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants. The DMH also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently, administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. As mentioned, in recent years of budget restrictions, the community mental health centers have also made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers. In FY 2008, the Legislature made and the Governor approved a deficit appropriation of an additional \$10 million in state matching funds for community mental health. The legislation that provides for the establishment, structure and operation of the regional commissions for mental health/mental retardation also authorizes participating counties to levy up to two mills tax for programs designated by the regional commission. The DMH also performs fiscal audits of programs receiving funding through its Bureau of Administration.

Sources listed under the heading of "Funding" within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under "Funding" does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited to those providers who receive specific program grants (including CMHS grants) and may be limited to those adults or children served through the grant.

System of Care Development

The system of care for children with serious emotional disturbance has grown significantly since the establishment in 1980 (effective in 1981) of the DMH Division of Children and Youth Services. Since system development historically has emphasized interagency collaboration, most objectives pertaining to system of care development are included under Criterion 3 that follows. As is evident throughout this plan, the process of development of the system of care in Mississippi has involved many concurrent and overlapping initiatives, during the past decade. The development of the system of care has involved cooperative administrative and policy changes at the state and local levels, which in some areas were facilitated by legislation. The Ideal System Model described previously in this section is based on a philosophy of services reinforced in the state through the implementation of statewide and local Child and Adolescent Service System Projects (CASSP) in the mid-1980's and the 1990's. Since 1988, the DMH and the MS State Mental Health Planning and Advisory Council, including the Children's Services Task Force of the Planning Council, have worked to develop program components within that system model.

Mental Health Transformation Activities: Improving Coordination of Care Among Multiple Systems

The **State-Level Interagency Case Review/MAP Team**, developed in 1990 and described in detail under Criterion #3, has continued to serve as an effective mechanism for major child and family service agencies to work together at the state-level to resolve difficult issues specific to individual children with serious emotional disturbance. Agencies' work on the team keeps them informed of the needs of families and youth with the most intensive needs, which facilitates their involvement in further development of a comprehensive system.

Wrap-Around Approach and Local MAP Team Development: The concept of using first the State-level Interagency Case Review Teams and now also local interagency teams, referred to as Making a Plan (MAP) Teams, to address the needs of youth with a history of or at high risk for hospitalization or institutionalization has continued to be a major strategy in development of the system of care. Initial efforts to pilot this wraparound approach in the state at the local level were through the Mississippi Connections project, which was implemented through 1993 state legislation and involved the pooling of a designated amount of state resources from major child/family service agencies (representing mental health, human services (child welfare), education, health and Medicaid). Legislation extending the project was passed in FY 1996 and again in FY 2000. These agencies worked together with MS Families As Allies for Children's Mental Health, Inc. (MS FAA) on the state-level Children's Advisory Council (CAC), established legislatively to pilot a regional interagency coordinated care approach to serving children with serious emotional disturbance with the most intensive needs. The initiative was implemented initially in Forrest and Clay counties. A third site in the Hinds County-Jackson metro area was developed as the site for implementation of a comprehensive service system project funded in September 1999 through the federal Center for Mental Health Services, known as the COMPASS (Children of Mississippi and Their Parents Accessing Strengths-based Services) project. During the sixth year, efforts focused on sustainability in the area of service delivery and infrastructure development. School-based services provided by Hinds Behavioral Health Services that were facilitated through the project have continued.

In FY 2006, the MS DMH Division of Children and Youth Services was awarded funding from SAMHSA for a second Comprehensive system of Care Project. This project is in its third year of implementation, during which services are being provided through the wraparound process for children affected by severe emotional disturbance (SED) and or co-occurring SED and substance misuse in a region of the state (Forrest, Lamar and Marion counties) that has high need for, but low availability of services that could have also served as a model for other rural areas. Mississippi Families As Allies for Children's Mental Health, Inc. (MS FAA) and Pinebelt Mental Healthcare Resources (Region 12 CMHC) are partners with the DMH Division of Children and Youth Services in leadership, staffing, and support of the five-year project, which has been named commUNITYcares (uniting neighborhoods – integrating through youth).

Mental Health Transformation Activity: Supporting Individualized Plans of Care (NFC Goal 2.1)

In Mississippi, as the concept of wrap-around is implemented further, it is expected that individualized service plans be designed through a family- and child-driven, strengths-based

needs assessment process. A team, including representatives of the family and various child and family service providers, develops the initial service plan for a child. The wraparound process, as demonstrated by the COMPASS project and commUNITY cares, takes advantage of an interagency, interdisciplinary approach through which some providers have access to flexible, non-categorical funding. Additionally, local interagency and family Making a Plan (MAP) teams will continue to be supported in implementation of a strengths-based assessment approach that leads to use of the child's and family's strengths in defining and providing an appropriate, coordinated array of services and supports. Presently, community mental health children's service providers in 15 CMHC regions of the state are using this approach through Making A Plan (MAP) teams. Currently, there are 36 MAP Teams with plans for expansion in FY 2010.

MAP Team Coordinators meet bimonthly to obtain further training and technical assistance from DMH Division of Children & Youth Staff or representatives from other child serving agencies, and Mississippi Families As Allies for Children's Mental Health, Inc. In August 2007, the MAP Team Coordinators participated in a concept mapping process to identify areas on which to focus their efforts, as well as actions steps that are important and feasible to enhance MAP Team functioning. In August 2008, the MAP Teams participated in a concept mapping follow-up assessment where progress was measured in accomplishing the actions that had been defined in 2007 as necessary to improve MAP Teams functioning. Objectives to continue to expand and strengthen the functioning of MAP teams statewide are described further under Criterion #3.

Quality Improvement System Development

As described in Section I, a significant piece of state legislation, the Mental Health Reform Act, also known as Senate Bill 2100, was passed during the 1997 Session of the Mississippi Legislature. Some of the specific parameters of the legislation that continue to impact development of the system of care for children/youth with SED in particular are those provisions that address uniformity of services, establishing interagency agreements, timeliness of services, crisis services, and overall accessibility of services. These portions of the Mental Health Reform Act were consistent and expanded on provisions of House Bill 1421 in FY 1996, which in effect gave the Department of Mental Health the authority to establish a set of minimum or core community mental health services for children that must be provided by community mental health centers. The implementation of parts of the Mental Health Reform Act pertaining to mental health services for children and youth is expected to increase the availability and uniformity of community-based services statewide. The Department of Mental Health continues to implement various provisions of SB 2100. Consistent with the call for increased access, quality and accountability of services in the Mental Health Reform Act, the Mississippi Department of Mental Health continues work to improve its system of program evaluation and planning, a key focus of which is further development of its data infrastructure and information management systems, described in more detail under Criterion 5. As noted throughout the plan, these efforts also address improving performance and outcome measurement and reporting at the local and state levels, including increasing capacity to report on National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Goal: To continue development of the program evaluation system, including implementation of the requirements of the Mental Health Reform Act of 1997 (SB 2100), to promote accountability

and to improve quality of care in community mental health services.

Peer Review

In addition to monitoring community mental health service providers' compliance with minimum standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in children/youth mental health services from among staff at community programs certified by the DMH. In FY 2008, the Division of Consumer and Family Affairs was created and has taken on the responsibility of coordinating the peer review process for adult services, as well as for children's services

In FY 2008, the Department of Mental Health provided a peer review satisfaction survey to CMHC directors, State Hospital Directors, peer reviewers and interested stakeholders. Using feedback from the survey, the Division made some changes to improve the peer review process in FY 2009. The peer review visits now involve a smaller, more focused team of a consumer representative, a family member and another interested stakeholder, and a sample of each type of program is visited during the peer review. The Division developed a manual guide for peer reviewers that describes services available by region, including the core services and other specific services offered in each region; pictures of service locations were added to addresses when applicable. Also, a pre-conference visit is now held with service providers, in addition to the exit conference at the close of the visit. As of May 2009, peer monitors for children's services participated in reviews at six CMHC sites (Regions 1, 8, 10, 12, 13 and 14).

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

Population: Children with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system

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

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

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

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

Special

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

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Results of the peer reviews make available to providers additional information/technical assistance specific to their programs that can be used to improve services.

Funding: Federal

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

National Outcome Measure: Client Perception of Care – Outcomes

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system

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

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

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

Special Issues: Piloting of the Youth Services Survey for Families (YSS-F) began in FY 2004. DMH had results for all major community services providers for FY 2004; however, since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; complete data was available later in the process. With consultation and approval from CMHS, the *YSS-F* was not administered in 2005 because of state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. As noted, new items were added to the survey instrument for the first time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC) Center for Health Informatics and Patient Safety to administer the official version of the *YSS-F* to a representative sample of parents of children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in

the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 children's services 2008 survey was 14%.

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

Action Plan: The DMH Division of Children and Youth Services will continue initiatives described in other sections of the State Plan to disseminate and increase the use of evidence-based practices at the 15 community mental health centers and other nonprofit service programs funded/certified by the DMH. The expansion of evidence-based practices and promising practices is aimed at increasing the quality and therefore, the outcomes of services provided to children with serious emotional disturbances and their families. Examples of initiatives to disseminate and expand the use of evidence-based practices include: the participation of several community mental health centers/other nonprofit service providers in learning collaboratives to provide training for implementation of trauma-focused cognitive behavior therapy (TF-CBT); the provision of training to staff at Gulf Coast Mental Health Center (Region 13 CMHC) in Child-Parent Combined CBT, Trauma Assessment Pathways (TAP), and Psychological First Aid; and, the provision of staff training in CBT and TF-CBT as part of the CommUNITY cares System of Care project in the Pine Belt Mental Healthcare Resources service area. Initiatives such as the operation of MAP teams and family education/support activities that facilitate involvement of parents/caregivers will also be continued.

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% Reporting Positively about Outcomes for Children	69% (Confidence Interval: 2) Baseline*	66%	65%	66%	67%
Numerator	224 positive responses	195 positive responses	198 positive responses	195 positive responses	206
Denominator	326 responses	296 responses	305 responses	296 responses	309

* As recommended by CMHS, additional items were added to the survey instrument for FY 2006 and subsequent years, which may have affected response rates; therefore, a new baseline was established.

Overall Results of Satisfaction Survey:

Results from the *Youth Services Survey for Families (YSS-F)* indicate perception of care about major domains of service, in addition to the National Outcome Measure on outcomes of services (described above). These domains include: access, general satisfaction, participation in treatment planning, and cultural sensitivity of staff, and are indicated in the following table.

Satisfaction Survey of Parents/Caregivers: Client Perception of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
1. % Reporting Positively about Access	95% (Confidence Interval:1) Baseline*	90%	87%	90%	91%
Numerator	309 positive responses	264 positive responses	264 positive responses	264 positive responses	279 positive responses
Denominator	326 responses	294 responses	303 responses	294 responses	308 responses
2. % Reporting Positively about General Satisfaction	91% (Confidence Interval:1) Baseline*	89%	88%	89%	89%
Numerator	296 positive responses	263 positive responses	266 positive responses	263 positive responses	275 positive responses
Denominator	326 responses	297 responses	303 responses	303 responses	309 responses
3. % Reporting Positively about Outcomes for Children	69% (Confidence Interval: 2) Baseline*	66%	65%	66%	67%
Numerator	224 positive responses	195 positive responses	198 positive responses	195 positive responses	206 positive responses

Denominator	326 responses	296 responses	305 responses	296 responses	309 responses
4. % Reporting on Participation in Treatment Planning for their Children	85% (Confidence Interval: 2) Baseline*	87%	86%	85%	86%
Numerator	278 positive responses	255 positive responses	261 positive responses	278 positive responses	265 positive responses
Denominator	326 responses	294 responses	303 responses	326 responses	308 responses
5. % Reporting High Cultural Sensitivity of Staff (optional)	97% (Confidence Interval: 1) Baseline*	95%	95%	95%	95%
Numerator	316 positive responses	280 positive responses	290 positive responses	280 positive responses	295 positive responses
Denominator	326 responses	295 responses	305 responses	295 responses	309 responses

* As recommended by CMHS, additional items were added to the survey instrument for FY 2006 and subsequent years, which may have affected response rates; therefore, a new baseline was established.

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

The Office of Constituency Services was established by the Department of Mental Health in response to a provision in the Mental Health Reform Act. The major responsibilities of this office include establishing and maintaining a 24 hour toll-free help line for responding to needs for information by consumers and their family members and other callers to the help line. This office is also responsible for responding and attempting to resolve consumer complaints about services operated and/or certified by the Department of Mental Health. Policies and procedures have been developed for resolving consumer complaints, both formally and informally. This office also maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. Information is accessible to all callers through staff via a toll-free telephone number. The number is accessible 24 hours a day, seven days a week. OCS has also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally-funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran. The DMH Minimum Standards for Community Mental Health/Mental

Retardation Services address services provided by OCS, including: (1) accessing the help line for information, referrals and complaints; (2) reporting serious incidents to DMH; and, (3) the availability of local grievance procedures, as well as procedures for grievances through OCS.

OCS staff participates in certification visits to each program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. This Office also continues to process and attempt to resolve consumer complaints through formal and informal procedures and track calls to develop reports for DMH management staff. Reports about the nature and frequency of calls to the help line (deleting all confidential information) are distributed quarterly to the DMH Executive Director, Bureau Directors and the OCS Advisory Council. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS has developed training modules on serious incident reporting, handling crisis and suicide calls, and any applicable minimum standards monitored by OCS. These modules are available as requested by any DMH-certified program. In FY 2009, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities). Additionally, OCS continues to publish, distribute, and update the "Directory on Disk" program to all DMH facilities and community mental health centers, as well as DMH Central Office staff. This directory gives service providers access to basic program/ service information for over 2000 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the statewide database (approximately 200 new or updated programs in FY 2009) used for information and referral; this process is also ongoing.

Objective: To maintain a toll-free consumer help line for receiving requests for information, referrals and for investigating and resolving consumer complaints and grievances and to track and report the nature and frequency of these calls.

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system.

Brief Name: Constituency Services Call Reports

Indicator: Continued tracking of the nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software.

Measure: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports).

Source(s) of Information: Data provided through the software, as calls to the OCS help line logged into the computer system.

Special

Issues: Dissemination of the directory on disk (a read only version containing program information) is being provided only to DMH-certified and funded providers who sign a use agreement to ensure preservation of accurate and current data.

Significance: The establishment of a toll-free grievance telephone reporting system for the receipt (and referral for investigation) of all complaints by clients of state and community mental health/retardation facilities is a provision of the Mental Health Reform Act of 1997. The concurrent development of a computerized current database to also provide callers with information and assistance facilitates access to services by individuals expands the availability of current and detailed statewide service information to community mental health centers.

Funding: State General Funds

Children's Mental Health Program Standards

Division of Children and Youth Services staff will continue to conduct certification visits to community mental health service providers to review compliance with DMH *Minimum Standards for Community Mental Health/Mental Retardation Services*. Revisions establishing minimum required community mental health services for children were included in those standards in 2002. Technical assistance on system of care development continued to be available to children's mental health service providers in FY 2008 and FY 2009. During FY 2009, Division of Children and Youth staff also participated in several DMH committee meetings to begin revising the 2002 *DMH Minimum Standards*.

Other Systems Development Initiatives

The Interagency Coordinating Council for Children and Youth (ICCCY), was extended through 2010 through Senate Bill 2991 passed in 2005 and is described in detail under Criterion #3.

Mississippi Youth Programs Around the Clock (MYPAC): Community-based Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant

In FY 2004, the MS Division of Medicaid, in coordination with the Department of Mental Health, was awarded a federal grant from the Centers for Medicare and Medicaid Services (CMS) designed to promote Community-Based Treatment Alternatives for Children (MS C-TAC). With the funds from this grant, the MS Division of Medicaid conducted a feasibility study to determine the potential costs and cost savings expected by developing a waiver for this population. In conducting the feasibility study, families of children with high intensity needs were included, so that their needs will be heard and addressed in the development of services. The total budget for the planning grant application was \$99,000, which was used over an approximately two-year period. The first priority was to include families of children with special needs in the process; 20% of the grant funds will be used to hold public meetings and provide assistance to family members in attending those meetings to provide their valuable insight at forums facilitated by

Mississippi Families As Allies for Children's Mental Health (MS FAA). As part of the project's planning phase, beginning in May 2005, MS FAA managed logistics for a series of focus groups held in seven regions in May, June and July 2005 to gather information from parents, foster parents and caregivers on gaps and needs in the community-based treatment/service system. The remaining 80% of the grant funds were used to employ consultants with Vanderbilt University to conduct the feasibility study, to determine a case rate for services, and to develop the implementation and evaluation plan.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for a Community-based Alternatives 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 will assist 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 will be 1970. Programs approved for funding under this demonstration grant will include 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and wrap around teams that will develop individual service plans. Mississippi Medicaid's resulting research data will be evaluated for cost effectiveness, quality of treatment, and outcomes for the children involved. The CA-PRTF demonstration grant, which will be administered by the Mental Health Programs Bureau, Division of Special Mental Health Initiatives within the Division of Medicaid, will only operate as a waiver and will compare cost of PRTF care to the cost of the waiver. The amount of the grant, which is \$49 million, is to be dispersed over a five-year period and can only be used for the expenses incurred by this waiver program. 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 SED, a reduction in the overall cost to the State, and an improved system of care for youth with SED.

Mental Health Services

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

Youth Suicide Prevention

In October 2006, the Mississippi Department of Mental Health, Division of Children and Youth, received a Hurricane Katrina-Related Youth Suicide Prevention Grant from the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, to develop and implement youth suicide prevention and early intervention activities to benefit youth and young adults adversely impacted by Hurricane Katrina. The targeted geographical area includes the 49 counties declared for individual assistance. Part of the grant structure and governance was the development of both a local interagency suicide prevention committee and a statewide advisory council. The local interagency suicide prevention committee includes key local

stakeholders and provides oversight of grant implementation in the proposed six coastal counties. During FY 2007, the Division of Disaster Preparedness and Response was charged with the responsibility for the oversight and administration of the Hurricane Katrina-Related Youth Suicide Prevention Grant.

The MS Youth Suicide Prevention Council has met at least quarterly since its creation in late 2006. The MS Youth Suicide Prevention Council's role includes providing leadership and perspective for statewide planning and implementation of prevention and early intervention strategies, including implementation of a Comprehensive State Plan for Youth Suicide Prevention. Representatives on the state level council are from the Mississippi Department of Education, the Mississippi Department of Health, the Jason Foundation, Jackson State University, Mississippi College, the Office of Attorney General, and Catholic Charities, and also include a survivor of a family member who completed suicide, a child psychologist in private practice, Hurricane Katrina-Related Youth Suicide Grant Local and State Project Coordinators, a Community Mental Health Center Children's Services Coordinator and staff from the Mississippi Department of Mental Health, Division of Children and Youth Services and Division of Disaster Preparedness and Response. In FY 2008, the MS Youth Suicide Prevention Council coordinated the first annual Youth Suicide Prevention Conference, which included workshops on The Role of the Church in Suicide Prevention, Trauma and Suicide, Surviving After a Suicide in the Family, Prevention of Suicide in Schools and on College Campuses, and Risk Factors. In September 2009, a Youth Suicide Prevention Pre-conference Workshop will be presented in association with the Mississippi Alliance for School Health Annual Conference.

Part of the funding from closure of a group home by a provider has been reallocated to enhance outreach and training (to be provided through Catholic Charities, Inc.) for school personnel in identification of suicide risk in the central and northern parts of the state (areas not addressed through the Hurricane Katrina-Related Youth Suicide Prevention Grant).

Goal: To facilitate statewide development and implementation of Youth Suicide Prevention and Intervention Strategies

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

Indicator: Number of trainings or workshops related to youth suicide prevention conducted outside of youth suicide prevention grant activities.

Measure: The number of ASIST, safeTALK training and presentations at workshops/seminars by staff on suicide prevention

Mental Health Transformation Indicator: Data Table C1.2	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Number of suicide awareness, prevention sessions/workshops	Not an objective in Plan	Not an objective in Plan (project initiated)	9 districts (in six coastal counties); 14 districts and 3 additional schools (with special accreditation) in counties in other parts of state (outside coastal counties)	1 ASIST Training, 4 safeTALK, 4 presentations at workshop/seminars	1 ASIST Training, 4 safeTALK, 4 presentations at workshop/seminars

Strategy: Several DMH staff, as well as other staff from nonprofit service providers participating on the Youth Suicide Prevention Advisory Council have been trained in ASIST and safeTALK. These staff conduct training upon request by mental health centers, universities, community colleges and other community agencies. Other members of the Youth Suicide Prevention and Advisory Council are available to conduct workshops and presentations on youth suicide prevention and awareness to community organizations, to other agencies, or at conferences, when requested.

Source of Information: Monthly Activity Reports Forms

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

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

Prevention/Early Identification and Intervention Services

Prevention programs provide services to vulnerable at-risk groups prior to the development of mental health problems. Children who are especially vulnerable include children in one-parent families, children of parents with mental illness, children of parents with alcohol abuse problems, children of teen parents, children with an incarcerated parent, children experiencing severe deprivation, children who have been abused or neglected, and children with physical and/or intellectual handicaps.

Early Intervention implies that intervention is implemented as early or as soon as problems are

suspected and/or identified. Early intervention programs, which often are designed to include collaboration among service programs, are intended to intervene at the earliest possible time with troubled youth. However, many of these youth who come to the attention of providers through early intervention programs are often found to have serious behavioral or emotional disorders requiring more intensive and perhaps multiple, special services. Existing early intervention mental health programs funded through the DMH target primarily youth who have been abused (sexually/physically/emotionally) and single teenage mothers.

In FY 2009, DMH continued to provide funding to three prevention programs. As of March 2009, Vicksburg Child Abuse Prevention Center (CAP) had served 104 children from 38 families, Family-and Vicksburg Family Development Center had served 130 children. As of January 2009, services funded by DMH at Family Support Center for Metro Jackson were suspended. The Division of Children and Youth Services does not anticipate funding this third program in FY 2010. Prevention services supported through state funds from DMH and provided to these families include home visits, prenatal education, parenting education classes, preschool classes, and sibling intervention groups. With DMH state funds, the Exchange Club of Vicksburg CAP Center provides a Parent Aide Program to families with child abuse/neglect programs. This program includes home visits, case management services, instructional activities, information and referral services, support services, parent education classes, and follow-up. DMH continued to fund Pine Belt Mental Healthcare Resources and the Vicksburg Family Development Services for specialized multidisciplinary sexual abuse prevention programs at the beginning of FY 2009. Due to a decrease in the final FY 2009 CMHS Block Grant award, funding for the specialized program operated by Pine Belt Mental Healthcare Resources could not be renewed after March 2009. As of March 2009, Vicksburg Family Development Service had served 88 children from 54 families and Pine Belt Mental Healthcare resources had served 54 children from 54 families, for a total of 142 children served.

The DMH also participates in statewide child abuse prevention efforts by having a representative on the State Board for the Children's Trust Fund. This fund is drawn from \$1.00 fees on each birth certificate and is utilized to support projects across the state designed to prevent child abuse. The funds collected from these fees and other donations are used to encourage and provide financial assistance for direct services to prevention 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: To further develop and/or enhance the prevention/specialized early intervention service components of the Ideal Service System Model for children with serious emotional disturbance.

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Prevention/specialized early intervention programs funded.

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

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

PI Data Table C1.2	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Prevention/Early Intervention–Funded Program	3 programs funded; (352 children/171 families served)	3 programs funded; 428 children served	3 programs funded; 1105 children served	3 programs funded	2 programs funded

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

Special Issues: None

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

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

In FY 2009 (as of March 2009), seven community mental health centers and Catholic Charities had 44 specialized day treatment programs for children, ages three to five. Technical assistance contacts had been provided to six CMHC regions (6, 8, 9,10, 12, and 14) pertaining to children’s mental health services for children with SED under the age of six years.

Objective: To continue to provide technical assistance through the Division of Children and Youth Services to encourage providers to make children’s mental health services

available to serve children with SED under the age of six years.

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Early intervention technical assistance

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

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

Source(s) of

Information: DMH Division of Children and Youth Services monthly staffing report forms.

Special

Issues: None

Significance: The DMH Division of Children and Youth Services encourages and supports programs that include services to identify and intervene with children under the age of six with a serious emotional disturbance to provide identification of problems and intervention as early as possible.

Funding: Federal, state, and local

Diagnosis and Evaluation Services focusing on assessment of primary needs of children suspected of having an emotional or mental disorder continued to be available through the 15 regional community mental health centers. Revised minimum standards (effective July 1, 2002) that describe specific criteria and documentation requirements for an eligibility determination of serious emotional disturbance include use of a functional assessment instrument/approach approved by the Department of Mental Health. More comprehensive, multi-disciplinary assessment services are available through the public school system, Headstart, the University of MS Medical Center Child Development Clinic, (UMMC Department of Psychiatry and Human Behavior), and private facilities/practitioners. The UMMC Pediatric Child Development Center is the fetal alcohol spectrum disorders assessment center in Mississippi and collaborates with the DMH Division of Children and Youth Services and the State FASD Coordinator. Also, the DMH Division of Children and Youth Services collaborated with the MS Department of Human Services (DHS) Division of Youth Services in use of the Massachusetts Youth Screening Instrument, version 2 (MAYSI-2) to screen youth in the juvenile detention centers for potential mental health service needs. Through the 1991 Expanded Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) process that includes assessment and treatment for mental

health, initial screening, followed by more comprehensive, multidisciplinary diagnosis and evaluation will continue. The diagnosis and evaluation component through this process is being provided primarily by private providers reimbursed through Medicaid.

During FY 2009, DMH began the process of revising the current DMH Minimum Standards, (2002 edition). During this process, Division of Children & Youth staff and Children's Services Coordinators from local mental health agencies are reviewing the potential use of standardized screening and assessments for children with serious emotional disturbance. The instruments being considered include The Ohio Youth Problems, Functioning and Satisfaction Scales (Ohio Scales) and the Trauma History Timeline.

Mental Health Transformation Activity: Individual Treatment/Service Planning (NFC Goal 2.2)

The DMH Division of Children/Youth Services continues to monitor community mental health service providers' compliance with established minimum standards for development of individualized treatment plans for children with serious emotional disturbance.

Day Treatment is a therapeutic service designed for individuals who require less than twenty-four (24) hour-a-day care, but more than other, less intensive outpatient care. Intensity and duration of the child's/youth's problem(s) are key factors in determining the need for day treatment. In FY 2009, technical assistance was provided to all 15 CMHCs for development of new day treatment programs. New programs were certified as needed.

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

School-based Day Treatment will continue to be available in FY 2009, and the Division of Children and Youth Services will provide technical assistance to school-based day treatment sites as needed. During FY 2008, CMHCs reported a total of 312 day treatment programs, with 50 center-based programs and 262 school-based programs.

Outpatient Services, which include individual, group and family therapy, will continue to be available through the 15 CMHCs and some other nonprofit programs. In FY 2008, a total of 25,285 children with serious emotional disturbance were reported as having received outpatient services through the 15 community mental health centers, including individual, group, or family therapy services.

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

School-Based General Outpatient Services

Current *DMH Minimum 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.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of school-based general outpatient services

Indicator: Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families.

Measure: Number of regional community mental health centers through which general outpatient services for children with serious emotional disturbance are made available (offered) to schools (Offered by 15 CMHC Regions).

PI Data Table C1.6	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Availability of School- based Outpatient Services (Offered to schools)	Provided in 15 CMHC Regions	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions; 662 school-based outpatient sites (FY data spans two school years).	Offered by 15 CMHC Regions	Offered by 15 CMHC Regions

Source(s) of

Information: DMH Division of Children and Youth Services records/reporting; Annual State Plan Survey

Special

Issues: *DMH Minimum Standards for Community Mental Health/Mental Retardation Services*, effective July 1, 2002, require that CMHCs offer school-based outpatient therapy to each school district in their region or provide documentation of refusal of the service by the district.

Significance: Revisions to the DMH Minimum Standards require that each CMHC offer school-based outpatient therapy to each school district in their region.

Funding: State and federal funds

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

Therapeutic Nursing Services

Nurses provide therapeutic health interventions that are directly related to mental health, such as education regarding diagnosis and medications, physical observations and assessments, monitoring of medications, development of individualized health objectives as part of the individualized treatment plan, and assessment of extrapyramidal symptoms. In FY 2009, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools and by mid-year, these nurses had made 10,309 contacts, which included services such as providing education for children/youth with SED, their families and teachers; conducting physical observations and assessments, monitoring medications; and monitoring sleeping habits. Region 8 nurses had provided 13,549 contacts, which included nursing assessments, medication monitoring, and physical observations for these children receiving outpatient services through Region 8 CMHC; the nurses also participated on the Rankin County MAP team.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of funding for therapeutic nursing services.

Indicator: Availability of funding to targeted community mental health regions to provide ongoing therapeutic nursing services to children with SED.

Measure: The number of regions to which DMH will provide funding for intensive therapeutic nursing services for children with serious emotional disturbances.

PI Data Table C1.8	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Regions w/ DMH Funding for Intensive Therapeutic Nursing Programs	2 regions funded				

Source(s) of

Information: Therapeutic nursing monthly summary form

Special

Issues: Designated Division of Children and Youth staff continues to provide technical assistance to the CMHC providing these nursing services and monitors the delivery of such services in accordance with requirements of the RFP. Additional data tracked through these projects include the total number of children served, and, in the rural area project, the number of contacts with children, and further, in the rural/urban area project, the number of hours of service.

Significance: The registered nurses will be available to provide mental health nursing services to children with SED, such as information about medications, physical observations/assessments, monitoring of behavior, eating and sleeping habits, assistance with health objectives on treatment plans, etc.

Funding: Federal funds

Respite Services 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. Ideally, respite services may be provided in-home or out-of-home by trained respite workers or counselors, as community-based residential or nonresidential services. Mississippi Families As Allies for Children's Mental Health, Inc. (MS FAA) provides respite services and is the administrator for training for respite program. By mid-FY 2009, Mississippi Families As Allies for Children's Mental Health, Inc. had provided training to 20 additional respite providers and reported serving 174 youth. Harden House had provided respite training to 19 additional respite providers and reported serving 48 youth. MS FAA is projecting training 55 more providers in FY 2010.

Goal: To develop the respite services component of the Ideal System Model for children with serious emotional disturbance.

Objective: To continue to make available funding for respite service capabilities.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Respite program funded

Indicator: Continuation of funding from DMH to support the implementation of respite services.

Measure: Number of respite providers available during the year (75)

PI Data Table C1.9	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# New Respite Providers Trained	40 respite providers trained; 82 respite providers available statewide; 175 children served.	20 respite providers trained by MS FAA, including five new providers; Harden House trained 52 respite providers	22 respite providers trained by MS FAA; Harden House trained 64 respite providers; all providers trained were new.		
# Respite Providers Available				50	75

Source(s) of Information: Annual State Plan Survey

Special Issues: None

Significance: Respite is a service identified by families and representatives of state child service agencies, as well as other stakeholders, as a high need service for families and children with SED to support keeping youth in the home and community. The need for this service and for training of providers because of attrition is ongoing.

Funding: CMHS block grant, state, and local funds, federal, and/or other grants as available

Housing

Community-Based Residential Treatment Services

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

Therapeutic Foster Care (TFC) Services continue to be an important community-based component of the Ideal System Model, 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. TFC provides the child with the special attention he/she needs to adapt to a

completely different home environment. The major barrier in expanding these homes is the difficulty in finding families to serve the increasingly difficult-to-serve children who need foster care. These children include, but are not limited to, children/youth who demonstrate severe emotional/mental disorders, who may have sexually reactive disorders, oppositional-defiant disorders, conduct disorders, may be delusional, and/or, at times, may be suicidal. Expectations for therapeutic foster care are high. The services continue to be accessible and available for children with more intensive needs in a targeted number of specialized homes with more intensive therapeutic and support services.

As of March 2009, DMH continued to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. In FY 2009, DMH Division of Children and Youth staff continued to make available technical assistance to existing therapeutic foster care programs and/or to other programs seeking DMH certification to support provision of therapeutic foster care services that meet DMH Minimum Standards.

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

Sources of Information: Division of Children/Youth Services Program grant reports

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

that therapeutic foster care is primarily funded by the MS Department of Human Services (DHS).

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

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
Percentage of children with SED served who received therapeutic foster care services*		.08	.09	.11	.08
Numerator: Number Receiving Therapeutic Foster Care Services*	26*	24	27*	23*	23
Denominator: Number of children with SED served by the state mental health agency (community	Not reported as percentage of total served in FY 2006	28,939	29,269	21,000	28,500

services)					
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*See Special Issues section, before performance indicator table.

The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by DMH. At mid- FY 2009, visits to provide technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages in Jackson, Methodist Children's Ministries, Mississippi Children's Home Society in Jackson and on the Gulf Coast.

Interagency Collaboration in Provision of Foster Care Services

The Department of Human Services (DHS), Division of Family and Children's Services, in addition to DHS internal processes, has continued to encourage social workers and other appropriate staff in the counties having one of the existing Making A Plan (MAP) teams to present cases to these teams of any child/youth in DHS custody for whom therapeutic placement was being considered. It is expected that through these MAP team reviews, needed mental health services through the CMHCs will be provided to an increased number of foster children who previously did not come to the attention of the local CMHC. Through the delivery of such services, as well as any other service that may be accessible through other MAP team agencies or other representatives/stakeholders, it is likely that the regular foster care homes for these children can become more therapeutic in nature. Some children may be able to leave the foster care system and return to live with their families with the support of the MAP Team services. The MS Department of Human Services, Division of Family and Children's Services continues to collaborate with DMH to find ways to expand and better utilize the MAP teams.

Therapeutic Group Homes are another major community-based residential service component of the ideal system of care. The primary mission of therapeutic group homes is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in therapeutic group homes are individuals who need intensive treatment in a community-based residential setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a therapeutic group home is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

During FY 2008, three therapeutic group homes funded by DMH and operated by St. Francis Academy in Picayune closed. As a result, the majority of the CMHS Block Grant funds for support of these homes was reallocated to Mississippi Children's Home Society for the planned expansion of a therapeutic group home on the Gulf Coast, which was noted in a modification to the FY 2008 State Plan under Criterion #5. Since the homes were funded for part of FY 2008, the target for the following objective in FY 2008 was not changed; however, the targeted number of homes to be funded in FY 2009 was decreased by three to reflect this change in the overall number of homes receiving DMH funding support.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Therapeutic group homes funded

Indicator: Continued availability of funding from DMH to support therapeutic group homes

Measure: Number of therapeutic group homes for which the DMH provides funding support (nine)

PI Data Table C1.11	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Funded Therapeutic Group Homes	13	Funding allocated for support of 13 homes, which served 237 children. An additional 129 youth served through homes certified, but not funded by DMH.	Funding for support of 12 homes was allocated, but one of the homes was not yet opened at the end of FY 2008; 209 children served through homes with DMH funding support; An additional 201 youth served through homes certified, but not funded by DMH	Nine	Nine

Source(s) of

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

Special

Issues: In FY 2009, DMH continued to certify nine therapeutic group homes that did not

receive DMH funding. The Department of Human Services provided funding for these homes and continues to require DMH certification, since they are therapeutic in nature.

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

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

Other Housing Services

Housing assistance is available through federal housing programs, administered through local housing authorities, and through some social services programs administered through the Department of Human Services. In addition to the therapeutic community-based residential programs described previously in this section, examples of housing assistance reported as accessed by individual community mental health children's service providers in FY-2008 included: federal housing assistance (subsidized housing/rental assistance/ Section 8 housing) through local housing authorities, financial assistance for rent, mortgage or utilities assistance and appliance purchases through local nonprofit volunteer organizations, including faith-based organizations/churches; winterizing assistance; housing for victims of domestic violence, mortgage counseling, appliance purchases, rental assistance through LIFT, Inc.; emergency housing through the American Red Cross; emergency/temporary shelter services through the Salvation Army; and, transitional housing through some local community mental health centers.

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

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

Target: To continue support and/or funding for an outreach coordinator and intensive crisis intervention services to youth/families served through these programs.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

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

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

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

Special Issues: According to Uniform Reporting System Guidelines for Table 15 (Living Situation), the number of children who are homeless/in shelters within all DMH-certified and funded community mental health programs are reported, including three programs that are specialized as they provide outreach and/or a safe place for homeless women and their children and homeless children who have been removed from their homes due to abuse/neglect. Therefore, the percentage of youth who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of children served by these specialized programs occur. DMH is continuing work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and ongoing efforts to improve data integrity might result in adjustments to baseline data, therefore, trends have been tracked for another year (in FY 2009) to better inform target setting in subsequent Plan years.

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

Action Plan: DMH will continue to provide funding and support for three specialized programs serving homeless children/youth with SED, described in separate objectives under Criterion 4 in the State Plan. Provision of partial funding for an Outreach Coordinator at Our House “Host Home” program facilitates outreach and identification of youth in need of comprehensive services because of their homelessness, including youth with serious emotional disturbances. Gulf Coast Women’s Center for Nonviolence provides shelter for children and their mothers who are experiencing violence at home. Through Gulf Coast Mental Health Center, a therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the local shelter. The local shelter services children who have allegedly experienced abuse and/or neglect

DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile in FY 2005 through FY 2008.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Performance Indicator					
% of youth reported homeless/in shelters	.3%	.2%	.25%	.2%	.26%
Numerator: # youth reported homeless/in shelters by DMH certified/funded providers	98	63	78	63	80
Denominator: # All youth reported with living situations by DMH certified/funded providers, excluding Living Situation Not Available	30,621	29,622	31,099	29,622	29,955

Educational Services

Children with serious emotional disturbance who meet eligibility criteria in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. Additional information on services provided by local systems under the Individuals with Disabilities Education Act of (2004) are described under Criterion #3 that follows.

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. One community residential program for youth with substance abuse problems, The ARK, in Jackson, MS provides a State Department of Education accredited special school on campus. Two approved Department of Education teacher units are provided at Sunflower Landing, another community residential program for adolescents with substance abuse

problems. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. See Criteria #3 for additional information on interagency collaboration.

National Outcome Measure: Return to/Stay in School (URS Table 19B): See Criterion #3.

Services to Special Populations

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

As mentioned previously, substance abuse and mental health services in Mississippi are both administered by the Department of Mental Health, through the Bureau of Mental Health. Substance abuse prevention and treatment services provided through the DMH Bureau of Alcohol and Drug Abuse Services are described in a section that follows under this criterion. In more recent years, as recommended by the Children's Services Task Force of the MS State Mental Health Planning and Advisory Council, the Department of Mental Health began to explore strategies for increasing efforts to address the needs of youth with co-occurring disorders. For example, the Alcohol and Drug Studies School included sessions pertinent to co-occurring disorders for youth. Three, community-based residential programs funded by DMH for adolescents with substance abuse problems also address problems of youth with co-occurring disorders. Division of Children and Youth staff continues to monitor and provide technical assistance to these three programs. Beginning in FY 2009, the FASD Coordinator will provide training, information and support to women in one of the adult substance abuse residential treatment facilities. These women may be pregnant or may have children with them while they are receiving treatment. A report developed for the Interagency Coordinating Council for Children and Youth (ICCCY) in 2004 specifically addressed children/youth with SED who are at immediate risk of being inappropriately placed out of home or who are at risk of returning to out of home placement/admission. Among the recommendations in the report was for children and youth with dual diagnosis of serious emotional disturbance and substance abuse to be made a priority population in the statewide development of the system of care prescribed by the legislation that established the ICCCY (HB 1275, passed in 2001 and extended in 2005 in Senate Bill 2991).

Implementing a strategic plan to better address the needs of individuals with co-occurring disorders of mental illness and substance abuse is a major task in system transformation efforts. The DMH has pursued initiatives to improve services in this area for many years; most of those efforts were coordinated by what was formerly the Dual Diagnosis Task Force, which was restructured to become the Co-occurring Disorders Coordinating Committee. The group has functioned to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse and sponsored an annual conference addressing specific training issues in this area for both adults and children and developed program guidelines for grants to local providers to provide specialized services for individuals with dual diagnoses.

In February 2006, DMH utilized its Annual State Conference on Co-occurring Mental Health and Substance Related Disorders to further engage additional stakeholders in planning efforts and to

advance knowledge in the field about the evidence for service integration. These focused activities over approximately one year culminated in the development of a draft Strategic Plan for Co-occurring Disorders, developed by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative. The group drafted the plan through a two and a half-day intensive planning session in the Spring of 2006, facilitated once again by the COCE. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded.

The Co-occurring Disorders Coordinating Committee was reconvened in FY 2007 to review, refine and address objectives in the plan. Representatives of the Division of Children/Youth Services now serve on the DMH's Co-occurring Disorders Coordinating Committee, along with representatives from the Bureau of Alcohol/Drug Abuse, the Division of Community Services for Adults and the Division of Policy and Planning. Plans are to expand the membership to include additional individuals receiving services and family members. The committee includes representatives of DMH's Divisions of Adult Community Services, Children and Youth Services, Alcohol and Drug Services and Planning, as well as representatives of community services providers and an individual who has received services. Since SAMHSA's Co-occurring Disorders Center for Excellence (COCE) has effectively assisted the state over the last two years, additional technical assistance was received beginning in the summer of 2007 to continue progress on implementation of evidence-based integrated service models for the remainder of FY 2009.

In FY 2004, the Director of the Division of Children and Youth Services was given the responsibility to be State Coordinator for Fetal Alcohol Spectrum Disorders (FASD) issues. In this role, she was recognized by SAMHSA and the FASD Center for Excellence as an approved trainer and as the coordinator of FASD efforts in Mississippi and represented the state at the initial National Fetal Alcohol System Development Meeting. A full-time FASD project director was employed in June 2005. Since 2005, the DMH Division of Children and Youth Services co-sponsored an FASD Symposium for professionals and families. In April 2007, the FASD Project Director was designated as the State FASD Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS AC-FASD). An FASD contract with Northrop Grumman was initiated in February 2008 to work through the CMHCs and the MAP Teams statewide to screen, diagnose and treat children with FASD.

As of March 2009, the Director of the Prevention Unit in the Bureau of Alcohol and Drug Abuse had been seated on the FASD Task Force. Division of Children and Youth Services staff participated in the 2nd Annual School for Addiction Professionals and provided FASD information for the attendees. As of March 2009, a total of 432 children have been screened for FASD through the local CMHC MAP teams. A Division of Children and Youth Services staff member continued to participate on the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-occurring Disorders Coordinating Committee and the Underage Drinking Task Force. The Children and Youth Services staff member continues to serve on the planning committee for the MS School for Addiction Professionals. Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK, Sunflower Landing and the CART House, which serve youth with co-occurring disorders.

- Goal:** To further the identification and provision of appropriate services to special difficult-to-serve populations.
- Objective:** To further develop the linkage between the Division of Children and Youth and the Bureau of Alcohol and Drug Abuse regarding issues of children/youth with SED, FASD, and substance abuse problems.
- Population:** Children with serious emotional disturbance or at risk for emotional illness
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Collaboration between children/youth behavioral health and alcohol/drug abuse services.
- Indicator:** Collaboration between the Division of Children & Youth and Bureau of Alcohol & Drug staff in exchange of information, training opportunities, and participation in Task Forces and Committees.
- Measure:** Continuation of the participation of children & youth services staff on related Bureau of Alcohol and Drug Services Task Forces, Committees, and activities that targets services to youth; tracking of the number of technical assistance and certification visits by DMH staff to programs implementing and/or planning programs to serve youth with a dual diagnosis of substance abuse and emotional disturbance; and tracking the number of children screened for FASD by the local MAP Teams.
- Source(s) of Information:** DMH Division of Children/Youth Services monthly staff forms
- Special Issues:** Division of Children and Youth Services staff members continue to collaborate with the Division of Alcohol and Drug Abuse. Division of Children and Youth works with Division of Alcohol and Drug Abuse staff to monitor and provide technical assistance to three DMH-funded residential programs that include some children/youth with co-occurring disorders
- Significance:** The DMH Director of the Division of Children and Youth Services and the Director of the Division of Alcohol and Drug Abuse collaborate closely to improve and further develop the options for children/youth with SED and substance abuse to be included in the system of care. Also, a staff member in the Division of Children and Youth participates on the Co-occurring Disorders Coordinating Committee, and a staff member of the Division of Alcohol and Drug Abuse participates on the Children's Services Task Force of the State Mental Health Planning and Advisory Council.
- Funding:** Federal and state
-

As of March 2009, 432 children ages 0 – 7 years had been screened for Fetal Alcohol Spectrum Disorders (FASD). Of this number, 56 were identified as needing a full diagnostic evaluation at the FASD diagnostic clinic at the University of Mississippi Medical Center (UMMC) to determine if they had FASD. To date, six children have been diagnosed with FASD.

Goal: To identify children/youth with Fetal Alcohol Spectrum Disorders (FASD) and identify services to meet individualized needs of these children.

Objective: To make available FASD screening assessments through the 15 CMHCs and the MAP Teams to identify children/youth that screen positive for possible FASD and need to receive a diagnostic evaluation to determine if an FASD diagnosis is warranted.

Population: Children and youth with serious emotional disturbance or at risk for serious mental illness who are suspected to have an FASD.

Criterion: Comprehensive, community-based mental health system.

Brief Name: FASD screening availability

Indicator: The number of FASD screenings conducted by the CMHC and/or the MAP Team in which community service providers make available FASD screening in accordance with DMH minimum standards or which submit an acceptable Plan of Correction if not in compliance with standards

Measure: Count of the number of FASD screenings conducted each year in or through the CMHCs and the MAP Teams.

PI Data Table	FY 2008 (Estimate)	FY 2009 (Target)	FY 2010 (Target)
FASD screenings conducted	Not an objective in the FY 2008 State Plan, but it is estimated that 1,848 screenings will be conducted	800	800

Source(s) of Information: DMH Division of Children and Youth Services monthly service report forms and MAP Team referral reports.

Special

Issues: The local MAP Team coordinators will be responsible for coordinating the FASD screening, helping refer children for diagnosis, ensuring inclusion in the child's treatment plan, and coordination of provision of services.

Significance: The DMH Division of Children and Youth Services encourages and supports screening children with a serious emotional disturbance for possible fetal alcohol spectrum disorders in those cases where indicated in order to provide identification of problems and intervention as early as possible.

Funding: Federal, state and/or local funds

The DMH Bureau of Alcohol and Drug Abuse Services reorganized the statewide conference on co-occurring disorders in FY 2008 and included co-occurring disorders and issues pertaining to adolescents among the topics addressed at the state's first Alcohol and Drug Studies School. As of March 2009, a Children and Youth Services staff member was designated to continue participation on the Co-occurring Disorders Coordinating Committee. Additionally, the System of Care Project (CommUNITYcares), now in its third year of implementation and serving youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar counties, had held several workshops specifically addressing topics such as cognitive behavioral therapy techniques, strengths-based wraparound approaches, and implementation of the *Seven Challenges* program. The 2nd Annual Mississippi School for Addiction Professionals held January 20-23, 2009, provided several sessions on youth with co-occurring disorders.

Objective: The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned for FY 2010

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

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

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

Special

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

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

Funding: Federal and state

Community-based Residential Treatment Programs for adolescents with substance abuse problems provide treatment services for youth who need intensive intervention. These programs have a schedule of activities that includes 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. In 2009, DMH continued to provide funding to three programs, which make available 56 beds for chemical dependence residential treatment for adolescents, some of whom also had a serious emotional disturbance. As of March 2009, the three programs had served 57 adolescents with substance abuse problems or co-occurring disorders of substance abuse and SED in a community-based residential treatment. Sunflower Landing served 20 youth, CART House served 21 and the ARK served 16 youth. DMH will continue to make funding available to these three programs in FY 2010.

Objective: To provide funding to maintain 56 beds in community-based residential treatment services for adolescents with substance abuse problems.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of community substance abuse treatment program beds

Indicator: Availability of community-based residential treatment program services for adolescents with substance abuse problems provided through sites in FY 2010.

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

PI Data Table C1.12	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Beds Funded Residential	146 youth served in 56	56 beds available; 175 youth served	56 beds available; 146 youth served	56 beds available	56 beds available

Treatment Program	beds				
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Source(s) of

Information: Division of Children/Youth Services Residential Monthly Summary Form/Grant Proposals for three community-based residential treatment sites.

Special

Issues: None

Significance: Adolescents who have co-occurring disorders (substance abuse/mental illness) will also continue to be accepted in these programs.

Funding: Federal funds

Youth with Dual Diagnoses of Mental Illness and Mental Retardation

In FY 2009, three CMHCs provided school-based day treatment programs for children and youth with co-occurring disorders of mental illness and mental retardation.

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

Multicultural Task Force

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the 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. The task force membership has been expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling has also been helpful. There are currently 36 members on the task force, including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-Mississippi; Mental Health Association Director; Jackson State University, School of Social Work; Jackson State University, SMHART (Southern Institute for Mental Health Advocacy, Research and Training); Jackson-Hinds Community Health Center, Ellisville State School, Jackson Healthcare Center, Grant Consultant; and Chairperson of the Mississippi State Mental Health Planning and Advisory Council. The task force is developing a cultural competency plan and has completed the Multicultural Competency Task Force Strategic Map and action plan for several of the strategic initiatives. The Multicultural Competency Task Force

Strategic Map mission statement 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.” The definition of cultural competency chosen by the task force members is: “the acceptance, understanding and embracing of all cultures.” “Culture” refers to an integrated pattern of human behaviors that includes language, thoughts, communications, actions, customs, beliefs, values and institutions of all individuals. As of March 2009, the Multicultural Task Force had organized the annual statewide Day of Diversity (October 13, 2008) and held a meeting on November 21, 2008. The Co-Chairperson of the Multicultural Task Force presented on cultural competency and disparities at the 27th Annual MH/MR Joint Conference. On April 17, 2009, a workshop (*Cultural and Linguistic Competency: Keeping It Real*), featuring Dr. Vivian Jackson with the National Center for Cultural Competency was held in Jackson, MS, and attended by 85 service providers. The task force has developed the *Draft, Mississippi Department of Mental Health Proposed Plan for Cultural Competency*, and a subcommittee met to develop the Communication Continuum for Sharing the Cultural Competency State Plan.

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Multicultural Task Force operation

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

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

Source(s) of

Information: Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made.

Special

Issues: None

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

Funding: State funds

Local Provider Cultural Competence Assessment

The Multicultural Task Force has also coordinated use of a cultural competence assessment instrument at the local level in Regions 1, 3, 4, 6, 7, 8, 11, 14 and 15 in previous years. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff have continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results. As of May 2009, Region 11 had received their local cultural competency assessment results and technical assistance in May 2009. The Co-Chair of the Multicultural Task Force has scheduled a meeting to discuss the assessment with Region 2 CMHC.

Objective: To expand the cultural competency assessment pilot project to include selected regions in the northern part of the state and additional areas in the central region.

Population: Children with Serious Emotional Disturbances

Criterion: Comprehensive, community-based mental health system.

Brief Name: Cultural competency pilot project expansion

Indicator: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project.

Measure: The number of community mental health centers/providers that participate in the local cultural competency assessment project.

Source(s) of Information: DMH Activity Reports

Issues: Participation in the project will be voluntary.

Significance: Results from the administration of the cultural competence assessment will be available to be used by the CMHC/provider to determine areas of cultural competence that might need to be addressed.

Funding: State and local funds

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

The Multicultural Task Force, which includes a representative of the Division of Children and Youth Services, continued to meet in FY 2009 to identify priority areas to be addressed related to cultural issues in community mental health service delivery. Children and youth service providers had the opportunity to participate in their local CMHC Day of diversity activities in

October 2008. The 20th Annual Lookin' to the Future Conference and the Mississippi Conference on Child Welfare offered one session on cultural diversity that addressed issues of a "future with changing faces." The DMH continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model; NCBI training sessions were conducted in Region 3, Region 8 (Copiah County, Rankin County and Simpson County) in April 2009.

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

Objective: To address cultural diversity awareness and sensitivity through training sessions or workshops focused on this topic.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

Brief Name: Cultural diversity training

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

Measure: Count of cultural diversity training sessions presented for children/youth service providers.

Source(s) of

Information: DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.

Special

Issues: None

Significance: DMH requires CMHCs and other DMH-certified programs to offer cultural diversity and/or sensitivity training to employees, in accordance with DMH Minimum Standards.

Funding: Local, state, and federal funds

The DMH *Minimum 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. The DMH Division of Children and Youth Services continues to require additional assurances from providers with which it contracts that training addressing cultural diversity and/or sensitivity will be provided.

Mental Health Transformation Activity: Improving Access to Employment

Rehabilitation and Employment Services

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

A representative of the Mississippi Department of Rehabilitation Services continued to attend State-level Interagency Case Review/MAP Team meetings. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, also participated on the Transitional Services Task Force and provided members with information on meeting the employment needs of youth in the transitional age range (18 to 25 years). The Executive Director of the Department of Rehabilitation Services continues to serve on the state executive-level Interagency Coordinating Council for Children and Youth (ICCCY) a representative continues to participate on the mid-management state level Interagency System of Care Council/ISCC (legislatively authorized in same legislation authorizing the ICCCY). (Current chairpersons are from the Mississippi Department of Mental Health. In September 2003, the Mississippi Department of Rehabilitation was awarded a national Social Security demonstration project grant designed to assist youth, ages 10 -25, in becoming employed through transition interventions from school to work and to reduce reliance on public benefits. (See Criterion #3, section on Initiatives to Assure Transition to Adult Mental Health Services for more detailed information on this project.). This five-year grant ended in September 2008; however, a no-cost extension was approved. Sustainability efforts between partners are being coordinated, and all plans will be in place before September 2009.

Specific examples reported of vocational/employment services accessed for youth by individual children's community mental health service providers in FY 2008 included: job skills training, academic and vocational training, GED programs, summer employment, Job Corps, employment placement, supported employment, transitional services, assistance with school uniforms and (job-related) transportation, basic technical skills training, occupational skills training, occupational therapy and development, and money management training.-These services were provided through a variety of state and local resources and providers, which can vary across communities, such as: Job Corps, the Mississippi State Employment Security Commission, WIN

Job Centers, the Mississippi Department of Rehabilitation Services, local school districts, Allied Enterprises,-Recruitment/Training Program of Mississippi, MIDD, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, Ability Works of Mississippi, county vocational-technical centers, Youth Challenge Program, the Mississippi Department of Human Services, MIDD West Industries, and the Mississippi Department of Transportation..

Substance Abuse Services

In Mississippi, substance abuse prevention and treatment services are also administered by the MS Department of Mental Health through its Bureau of Alcohol and Drug Abuse (BADA). Community mental health centers are the primary providers for both community mental health and outpatient substance abuse treatment for youth. As indicated previously and described further under Criterion #3, the two bureaus have increased collaborative efforts to better address the needs of youth with dual diagnosis of mental illness and substance abuse. Specific objectives addressing this group of youth were described previously under the section on Special Populations under this criterion. The existing substance abuse prevention and treatment system components administered by the DMH Bureau of Alcohol and Drug Abuse that address the needs of youth are described below:

Substance Abuse Prevention Services: DMH Bureau of Alcohol and Drug Abuse continues to provide funding to support prevention activities, statewide. Primary prevention services are provided through 15 community mental health/mental retardation centers and 13 other community-based private/public nonprofit free-standing organizations. All 28 programs use their funding to provide direct services to the mental health regions in which they reside. By funding all 15 Community Mental Health Centers, BADA ensures all 82 counties are provided prevention services.

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

In March 2006, BADA was awarded funds by the CSAP for a State Epidemiological Outcomes Workgroup (SEOW). In October 2006 this grant was incorporated into the newly awarded Strategic Prevention Framework State Incentive Grant (SPF SIG) (see next paragraph). The goal of the SEOW is to collaborate with other state entities to determine the scope and magnitude of substance abuse and associated problems in our state. The SEOW has two primary missions: use

data to enable the state to successfully report on all National Outcome Measures, and create epidemiological profiles for all substances to include profiles of need, patterns of consumption, and consequences of substance use. Each of the profiles consists of consumption patterns of the State at large, as well as prevalence trends in race, gender and lifespan. Mississippi's substance abuse prevalence rate is examined and compared to national data. As a result of collaboration with the Mississippi Department of Education, a website was created to provide data related to Mississippi's youth and their risk and protective factors. (See www.snapshots.ms.gov)

In October 2006, the MS Department of Mental Health was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The SPF SIG assists the Bureau in its endeavor to implement a comprehensive substance abuse prevention system that enhances our ability to plan, implement, monitor, and sustain effective prevention practices. Approximately 20 subgrants will be awarded October 1, 2008, to community-based organizations. The priority of the SPFSIG is to reduce alcohol use and related consequences to include alcohol-related motor vehicle crashes, binge drinking and drinking and driving among youth between the ages of 11 and 21. Successful applicants will implement evidence-based programs, policies, and practices that address this priority.

Tobacco prevention

The Bureau of Alcohol and Drug Abuse continues to assist the Office of the Attorney General to determine the annual rate of tobacco sales to Mississippi minors. Coordinated efforts continue with completing the regulatory requirements of the Synar Amendment and the Annual Synar Report. Mississippi has always been in compliance with negotiated federal Synar rates. The Bureau of Alcohol and Drug Abuse tobacco inspections began in March, 2008 and were completed in approximately six weeks. The final result this year was a non-compliance rate of 3.8%, which is substantially below the 20% maximum allowable non-compliance rate.

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

Substance Abuse Services for Adults and Children

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

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided these services. One of the free-standing programs, Metro Counseling Center provides day treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care. At the conclusion of FY 2008, there were 10,377 individuals who received these services.

Intensive Outpatient Services: These services are directed to persons who need more intensive care but who have less severe alcohol and drug problems than those housed in residential treatment. IOP services enhance personal growth, facilitate the recovery process and encourage a philosophy of life which supports recovery. These services are provided by 11 community mental health centers, 11 certified free-standing programs and 1 adolescent program, CARES Center/the Ark. In FY 2008, there were 1,412 individuals who received these services.

Chemical Dependency Unit Services: Inpatient or hospital-based facilities offer services to these individuals with more severe substance abuse problems and who require a medically-based environment. Treatment includes detoxification, individual, group and family therapy, education services and family counseling. BADA continued to make available funding to 4 certified programs and 1 adolescent program, which is the Bradley Sanders Complex, an extension of East MS State Hospital. At the close of FY 2008, there were 1,138 individuals who received these services.

Primary Residential Services: These services are for persons who need intensive residential treatment who are addicted to alcohol and drug problems. Services are easily accessible and responsive to the needs of the individual. In residential treatment, various treatment modalities are available, including individual and group therapy; family therapy; education services; vocational and rehabilitation services; recreational and social services. Adolescents who need primary residential treatment for alcohol and drug problems are provided intensive intervention. Individual, group and family counseling are offered as well as education programs at the appropriate academic levels. Adults and adolescents with a co-occurring disorder of mental illness and substance abuse are also provided treatment in a primary residential setting. These services are provided by 14 community mental health programs, 11 certified free-standing programs and 3 adolescent programs. In FY 2008, there were 3,338 adults and adolescents who received these services.

Transitional Residential Services: These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program before being eligible for admission to a transitional residential program. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2008, there were 827 adults who received these services.

Outreach/Aftercare Services: Outreach services provide information on, encourage utilization of, and provide access to needed treatment or support services in the community to assist persons

with substance abuse problems or their families. Aftercare services are designed to assist individuals who have completed primary substance abuse treatment in maintaining sobriety and achieving positive vocational, family and personal adjustment. These services are provided by 14 community mental health centers, 21 certified free-standing programs and 1 adolescent program. In FY 2008, there were 4,166 individuals who received these services.

Referral Services: During FY 2009, the Bureau of Alcohol and Drug Abuse updated and distributed the current 2009-2010 edition of the Mississippi Alcohol and Drug Prevention and Treatment Resources directory nationwide. The directory is also on the DMH Internet web site for those in need of services. During FY 2008, the Office of Constituency Services received and processed approximately 2,378 calls requesting substance abuse information or assistance in finding treatment and/or other related/support services. Over 24 categories of “problems/needs” were addressed.

Employee Assistance Program: During FY 2008, The Employee Assistance Coordinator updated and distributed the Employee Assistance Handbook to representatives of state agencies and organizations. The handbook entails the development of an employee assistance program including federal and state laws regarding a drug free workplace. The coordinator continued to provide EAP trainings across the state.

Specialized/Support Services: These services include vocational rehabilitation, which is provided to individuals in local transitional residential treatment programs through a contract between the Bureau of Alcohol and Drug Abuse and the Department of Rehabilitation Services. In FY 2008, vocational services were provided to 124 individuals. Other specialized/support services include providing treatment to individuals who have been diagnosed with a co-occurring disorder of mental illness and substance abuse. All 15 community mental health centers provide co-occurring services through SAPT block grant funds. The Bureau of Alcohol and Drug Abuse continued to provide funding to one of the state-operated psychiatric hospitals to manage a 12 bed group home for co-occurring individuals. In FY 2008, 10,991 individuals with a co-occurring disorder of mental illness and substance abuse were served. The substance abuse treatment system also includes special programs or services designed specifically to target certain populations such as women and children, DUI offenders and state inmates. At the close of FY 2008, there were 2,656 individuals who were admitted to a DUI program and 1,698 inmates admitted to the residential alcohol and drug abuse treatment program at the state penitentiary.

Private Resources

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 52 licensed and/or Certificate of Need (CON) approved beds in FY 2008 for adolescents. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

Health/Medical and Dental Services

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

resources, such as through community health centers/clinics, county health department offices, university programs and services and private practitioners. All children on Medicaid are eligible for Early Periodic Screening Diagnosis and Treatment (EPSDT) services, which include offering medical and dental services from Medicaid providers of those services if needed, as part of the treatment component of the EPSDT process. DMH Minimum Standards also require that residential programs for children with serious emotional disturbance have in place plans for providing medical and dental services.

Mississippi Health Benefits is a cumulative term for the programs available for uninsured children. These include traditional Medicaid and the Children's Health Insurance Program (CHIP Phase I, a Medicaid expansion program, and CHIP Phase II, a separate insurance program.) CHIP Phase II of MS Health Benefits Program was approved to increase income eligibility to 200% of the federal poverty level in December, 1999, and was implemented January 1, 2000. The same application is used by individuals to apply for Mississippi Medicaid and the separate insurance program. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP. It was originally estimated that 15,000 uninsured children would be eligible for Medicaid expanded and 85,000 for CHIP. From monitoring reviews of Division of Medicaid data and enrollment data, more children are being determined eligible for Medicaid. Current CHIP enrollment is over 67,000 children.

In families with income under 200% of the poverty level, uninsured children under the age of 19 are eligible for CHIP. As of January 1, 2005, determination for eligibility for Mississippi Health Benefits was transitioned from the Department of Human Services to the Division of Medicaid. At that time, the requirement for a face-to-face interview for application and redetermination was required. The following information must also be made available for all persons applying: proof of household income, proof of citizenship and identity and Social Security numbers for all applying. Applications and redeterminations can be made at the 30 Regional Medicaid Offices, as well as additional outstation locations. Outstation locations include: local health departments, hospitals, and Federally Qualified Health Centers. Also, under the CHIP plan, the six-month waiting period for children with previous creditable health insurance was eliminated in October, 2000. The program currently has zero waiting periods, meaning that the applicant must be without other health insurance at the time of application. The state must monitor the number of children enrolled since this policy change who have had health insurance coverage in the last six months. When that number is 15% of the number of children enrolled since October, 2000, the state must implement a crowd-out mechanism, such as a waiting period with specific exceptions. At such time, the state will survey families of children who have lost coverage in the last six months to identify the reason for lost or discontinuance of coverage. Results will be used to define possible exceptions to the waiting period.

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 152 delivery sites in Mississippi, further advancing President Obama's effort to provide access to health care for all Americans. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified

by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale. However, no one is refused care due to inability to pay for services. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

The MS Department of Health (DOH) also makes available certain Child Health Services statewide to children living at or below 185 percent of the non-farm poverty level and to other children with poor access to healthcare. The Child Health services include childhood immunizations, well-child assessments, limited sick child care, and tracking of infants and other high risk children. Services are preventive in nature and designed for early identification of disabling conditions. Children in need of further care are linked with other State Department of Health programs and/or private care providers necessary for effective treatment and management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age. Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. DOH partners with other state agencies and organizations to address child and adolescent issues through active participation with, but not limited to, the local MAP teams, State Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

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

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

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

Mental Health Case Management Services

Target Population: The following children/youth with serious emotional disturbances must be evaluated for the need for case management and provided with case management 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 (defined as Medicaid);
- Children/youth with SED who are receiving intensive crisis intervention services; and,
- Children/youth referred to the CMHC after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks for referral for CMHC services).

Model of Case Management

Case Management within Mississippi's service system for children with serious emotional disturbance is key to access, linkage and coordination of services across the system of care (Stroul and Friedman, 1986). Case management facilitates delivery of and movement among all services in the Ideal System Model. Within a conceptual framework of interagency collaboration and cooperation, the local case manager's function is to provide direct case management services, to monitor and track progress of children/adolescents, and to assist them and their families in accessing services. Case management involves aggressive outreach for the child and family. Case managers work with numerous community agencies and resources to develop and implement a comprehensive, individualized service plan, to facilitate access to services, to review progress, and coordinate services. The case manager has the responsibility of brokering services for children and families. In summary, functions of local case managers include: assessment of needs and resources to address those needs; planning for individual children and families, including identification of existing resources and/or constraints in implementing service plans; monitoring of progress of the child/family in relation to the service plan; linkage of services

within and across child service agencies; facilitating access to services; and, addressing internal or external constraints on achieving goals/objectives of the service plan.

Outreach and Expansion of Case Management Services

Assessment of the need for case management for children and youth with SED who receive substantial public assistance will continue to be provided by regional community mental health centers. Documentation of evaluation of need for case management services by the target population of children and the offering of such services will be maintained. Those who demonstrate a need through this assessment will be offered case management.

Goal: To make available case management services to children with serious emotional disturbance and their families.

Objective: To evaluate children with serious emotional disturbance who receive substantial public assistance for the need for case management services and to offer case management services for such families who accept case management services.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Provision of case management services

Indicator: Provision of evaluation services to determine the need for case management, as documented in the record, for children with serious emotional disturbance who are receiving Medicaid and are served through the public community mental health system.

Measure: Number of children with serious emotional disturbances who receive case management services (13,000)

PI Data Table C1.14	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# SED Receiving Case Management*	14,092	15,011	14,995	11,000	13,000

Source(s) of

Information: Compliance will be monitored through the established on-site review/monitoring process

Special

Issues: The DMH is continuing to implement a multi-year project, with support from the

CMHS Data Infrastructure Grant (DIG), to develop a central depository for data from the mental health system. As this system continues to be implemented within the FY 2009-2010 time period, downward adjustments in targets are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

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

Funding: Federal, State and/or local funds

See also objectives on Case Manager Training under Criterion #5.

The DMH *Minimum Standards for Community Mental Health/Mental Retardation Services* continue to require providers certified by DMH to establish and/or participate on a MAP Team. See objective under Criterion #3. Programs are also monitored on site visits to determine the utilization of a local MAP Team to serve children and youth with SED.

School Based Services (Consultation and Crisis Intervention), Mental Illness Management Services (MIMS) and Individual Therapeutic Support are case management services that became available for children with serious emotional disturbances in FY 2002.

School-Based Services are professional therapeutic services provided in a school setting that are more intensive than traditional case management services. School-based services include consultation and crisis intervention and must be provided by a Masters-level therapist/case manager.

Consultation is professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

Crisis Intervention is therapeutic engagement at a time of internal or external turmoil in a child's life, with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and/or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

As of mid-year FY 2009, CMHC Regions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13 and 14 had been certified by DMH to provide school-based case management services.

Mental Illness Management Services (MIMS) include activities that may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the child/youth live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider of these services, required by the more complex mental health needs of some individuals with serious mental illness. In addition, individuals receiving MIMS must be evaluated at least every six months to determine the individual's readiness to resume traditional case management and/or other appropriate services. MIMS may be provided in any appropriate community setting by a staff member who holds at least a Master's degree (in an appropriately related field) and professional license (for example, as a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Master's level Social Worker or a physician) or who is a Department of Mental Health Certified Mental Health Therapist.

At mid-year 2009, Regions 1, 2, 4, 10, 13, and 15 were approved for the provision of MIMS for children and youth services.

Individual Therapeutic Support is the provision of one-on-one supervision of an individual with serious mental illness during a period of extreme crisis, without which hospitalization would be necessary. The service may be provided in the youth's home, school or any other setting that is part of his/her environment. Individual therapeutic support focuses on the reduction/elimination of acute symptoms and is provided during a time when the youth is unable to participate in regular treatment activities, such as partial hospitalization or day treatment. This service must be provided by a staff member with at least a high school or equivalent degree who has completed certification approved by the Department of Mental Health. At the end of FY 2007, Regions 6 and 8 CMHCs were approved to provide individual therapeutic support services.

Activities To Reduce Hospitalization

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. An underlying purpose of the majority of the objectives in the State Plan is to prevent the need for and/or provide community-based alternatives to hospitalization and long-term residential or other out-of-home placement of children and adolescents, whenever possible. Since the initiation of the P.L. 99-660 planning process, efforts to expand/improve community-based mental health services for children and to foster and maintain interagency collaboration and coordination of services to respond to the multiple needs of children with severe disabilities in the community have been priorities of the Division of Children and Youth Services. Ongoing service expansion and interagency collaboration activities also reduce the risk of children being placed in out-of-home and/or out-of-state treatment settings.

Interagency collaboration activities, such as Making A Plan (MAP) Teams, seek to reduce the risk of children/youth being placed in out-of-home and/or out-of-state treatment settings. Specifically, MAP Teams work with children and young adults, up to age 21, who have a serious emotional disturbance and are at immediate risk for placement in an out-of-home treatment setting. MAP Teams work with children and their families to assess the strengths of the child and family in order to develop a comprehensive, individualized and strengths-based plan to meet the needs of

the child in his/her own home and community.

The State Level Review/MAP Team is another interagency collaboration activity designed to reduce the risk of children/youth being placed in out-of-home and/or out-of-state treatment. The State level Case Review/MAP Team reviews cases concerning children/young adults that have already been served by a local level MAP Team and for whom adequate services and supports cannot be found at the local levels. The State Level Case Review/MAP Team works with local MAP Teams to develop plans for children/young adults and their families that would also serve as an alternative to an out-of-home and/or out-of-state placement.

Pre-evaluation Screening and Civil Commitment Services, available through all 15 CMHCs, have as a major purpose to reduce the number of inappropriate admissions to the state psychiatric facilities and to ensure that community-based alternative services are available. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for commitment to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals (applies to youth age 14 years and over). The civil commitment process requires that the local CMHC conduct a pre-evaluation screening for the Chancery Court and the Youth Court to use to determine if the commitment process (including examination for inpatient or outpatient commitment) should continue. The pre-evaluation screener also provides useful information about available community services for the Court's consideration, if alternatives to inpatient commitment are appropriate. If the court determines there is a need to continue with the involuntary commitment process, the youth is evaluated by two physicians or by one licensed physician and one licensed and certified psychologist. The commitment examination is to determine if commitment should be made, either for inpatient or outpatient services.

The Department of Mental Health began making available training and certification to staff conducting pre-evaluation screening in April 1995. Implementation of a change in commitment law that requires single-point (CMHC) pre-evaluation screening of individuals being considered for civil commitment and subsequent training provided by DMH, facilitates coordination among the Courts, CMHC staff, and Court-appointed examiners throughout the referral, screening and examination process. It was also hoped that changes in the process will result in making the commitment process more standard (and thereby less difficult for consumers and families to navigate) across jurisdictions. In FY 2010, the DMH plans to continue training for community mental health center staff conducting pre-evaluation screening. Doing so facilitates a greater awareness of the system, communication, and coordination between the CMHC staff conducting the pre-evaluation screening and family members.

Acute Inpatient Services

Short-term, acute inpatient psychiatric services for adolescents with serious emotional disturbance are currently available statewide through two comprehensive state psychiatric hospitals (Mississippi State Hospital and East Mississippi State Hospital) and local public or private hospitals. Short-term public inpatient acute psychiatric services for children (statewide) are provided by Mississippi State Hospital; short-term inpatient chemical dependence treatment for adolescent males (statewide) is provided at East Mississippi State Hospital. The goal of the state inpatient facilities is to make available quality inpatient services to children/adolescents in the

state in need of this intensity of care, for whom these services are not otherwise available at the local, community level. In FY 2009, MS State Hospital operated a 10-bed unit for children and a 50-bed unit for adolescents in need of acute inpatient treatment. East MS State Hospital operated a 50-bed unit (located off the main adult campus) for adolescents in need of psychiatric or for adolescent males in need of substance abuse inpatient treatment. Both inpatient facilities provide education services through on-campus special school programs accredited by the Mississippi Department of Education. Admissions of youth to the state psychiatric facilities are governed by state statute and fall primarily into two categories: a) voluntary application for psychiatric services and substance abuse services; and b) involuntary admission by Chancery Court or Youth Court orders for psychiatric services or chemical dependence services.

Community-Based Emergency Response/Crisis Intervention

A major focus of state planning activities designed to reduce the rate of hospitalization of children with serious emotional disturbance has been on developing models for improving community-based response to emergencies and management of crises, with the aim of preventing the need for or providing alternatives to hospitalization in response to crises. The Children's Services Task Force, a committee of the MS State Mental Health Planning and Advisory Council, formed in 1990 to address children's mental health issues in more depth, directed much of its early work to developing a model for improving community-based emergency services/crisis intervention.

The major service components available through Hope Haven, a comprehensive crisis intervention program, include crisis intervention, child and family support, and outpatient services. Hope Haven also makes services available to youth who are homeless/runaway. A second model program funded by DMH and operated in Region 7, Community Counseling Services, serves seven counties (most of which are predominately rural) in the east-central part of the state. This program includes a crisis line specifically for children's services available across all seven counties, with linkages to other appropriate services. For children/youth in need of more specialized and intensive intervention, this CMHC focuses on two counties in which an array of specialized crisis services are made available through mobile crisis, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. Both comprehensive crisis programs utilize a 24-hour crisis hotline with mobile intensive intervention, enabling services to be provided quickly and efficiently at the youth's home. In FY 2000, Pine Belt Mental Healthcare Resources (Region 12 CMHC) began receiving state funds for operation of a third comprehensive crisis intervention/emergency response program. This program provides community-based crisis response services that are available on a 24-hour basis and an emergency on-call team both during and after work hours to act as a single point of entry into the program for two counties (Forrest and Jones) in the region. Additionally, since FY 2001 a fourth comprehensive crisis program, operated by Region 8 CMHC, has received DMH funding. As noted previously, Region 8 CMHC became a partner in the SAMHSA/CMHS Local System of Care grant project at the beginning of the fifth year of the six-year grant cycle, allowing for linkage to their model of crisis intervention services. In FY 2005, reallocated funding became available for development of a fifth comprehensive crisis service program in Region 4 (Timber Hills Mental Health Services, based in Corinth). Support for these five programs will continue in FY 2010.

Integration of Wraparound in Comprehensive Crisis Intervention Programs

All five non-profit providers of comprehensive crisis intervention programs are affiliated with local Making a Plan (MAP) teams. Catholic Charities, Inc. coordinates with the MAP teams in Hinds and Adams Counties. Region 8 coordinates with the MAP team in Rankin County. Community Counseling Services coordinates with the MAP teams in Clay, Noxubee, Oktibehha, Webster and Winston Counties.. Pine Belt Mental Healthcare Resources coordinates with the MAP teams in Jones, Forrest, and Lamar counties. Timber Hills Mental Health Services coordinates with the MAP Team in Alcorn County. The Department of Mental Health will continue to support expansion of crisis services for children, with the goal of establishing a statewide network of crisis management services.

Goal: To continue improvements in community-based emergency services/crisis intervention.

Objective: To continue to make funding available for five comprehensive crisis response programs for youth with serious emotional disturbance or behavioral disorder who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Comprehensive crisis response models funded

Indicator: Continuation of DMH funding to implement comprehensive intensive crisis response programs for youth with serious emotional disturbance or behavioral disorders who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement.

Measure: Number of comprehensive crisis response programs for which DMH provides funding (5)

PI Data Table C1.16	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Funded Crisis Response Programs	5	5	5	5	5

Source(s) of

Information: Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for four comprehensive crisis response programs.

Special Issues: None

Significance: These crisis programs provide a more comprehensive approach and service array to youth and families in crisis and will provide useful information in expanding and enhancing crisis services in other areas of the state.

Funding: State and local funds, CMHS block grant, and Medicaid

In FY 2009, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects: At mid-year, Region 3 CMHC had served 135 youth; Region 13 had served 140 youth; Region 15 had served 36 youth; Gulf Coast Women's Center had served 44 youth; and, Mississippi Families As Allies for Children's Mental Health, Inc. had served 185 youth.

Objective: To continue specialized outpatient intensive crisis intervention capabilities of five projects.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Intensive crisis intervention projects funded

Indicator: Continued funding by DMH for specialized outpatient intensive crisis projects (5)

Measure: The number of programs that receive DMH funding for specialized outpatient intensive crisis intervention projects. (5)

PI Data Table C1.17	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Funded Intensive Crisis Intervention Projects	5	5	5	5	5

Source(s) of Information: Division of Children/Youth Services Crisis Monthly Summary Forms/Grant Proposals for the specialized programs/monthly cash requests.

Special Issues: None

Significance: These specialized local programs facilitate the provision of more comprehensive crisis services that are designed to meet unique needs of children and families in additional areas of the state.

Funding: Local, state, Medicaid and CMHS block grant

Initiatives to Prevent Out-of-State Placement

As mentioned previously, the Department of Mental Health is continuing state- and local-level initiatives, most of which involve working with other agencies, to prevent and/or reduce out-of-home or out-of-state placement, such as the State-level Interagency Case Review/MAP Team, as well as local Making a Plan (MAP) Teams. These initiatives are discussed in more detail under Criterion 3.

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

In order to manage a crisis after problems are stabilized, other component services available to maintain a child within the community and to divert children and youth from hospitalization are as follows:

Medication Maintenance services are available to children with serious emotional disturbance through the 15 CMHCs. State funding, continues to be provided to support purchase of psychotropic medication for individuals with mental illness who are indigent, including children. Physician evaluations to monitor medication usage, effectiveness and side effects are also available. The DMH continues to provide state funding to support physician services through community mental health programs for children and adults who are not Medicaid eligible.

Respite Services could play a role in preventing hospitalization in some cases, especially if available as part of a comprehensive crisis management system. Objectives to continue implementation of respite programs for children with serious emotional disturbance in FY 2009 are described previously under this criterion.

Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependence Residential Treatment Services for Children and Adolescents all provide needed community-based alternatives to hospitalization and/or other out-of-home or out-of-state treatment for children with serious emotional disturbance. Objectives to maintain, improve, and/or increase these services are described under this criterion.

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

Continued development of family education/support networks and education/training activities and advocacy increase awareness across the system of care of appropriate community-based treatment alternatives to hospitalization or other long-term residential services, as well as of the need for increased support for and availability of these services. Advocacy have not only been a component of the ideal system, but also have been a part of the process of developing and implementing the system of care. Parent education/support and advocacy groups also are important in providing outreach to other parents/families and services, since these groups may be the “first contact” for information or service for some individuals. The Department of

Mental Health supported for the development of an education program specifically for parents and families of children with serious emotional disturbance, the Developing Families as Allies curriculum, which was first implemented in FY 1991 in five communities by parent-professional teams.

Division of Children and Youth continues to provide financial support and technical assistance to Mississippi Families AS Allies, Inc., (MS FAA), which as formed in FY 1991 and 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 a full-time Family Crisis Specialist 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. (See previous objective on Respite Services under this criterion.)

An increase in funding for family education and support continues to be available to MS FAA through the second Comprehensive System of Care grant (commUNITY cares). Other MS FAA components of commUNITY cares include youth leadership development; Family Time-Out respite and group respite (including therapeutic recreation. Families in community cares formed a Family Advisory Council and give input to commUNITY cares governance groups on vision, services and evaluation of the project. Funding for family education and support and respite can also be purchased with flexible funds made available to MAP teams across the state. It should be noted that MS FAA's relationship with the MAP Teams has been a significant factor in developing sites for family education and support.

Under the Statewide Family network grant, 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. DMH continues to make funding available for family education and support.

As of mid-year FY 2009, Mississippi Families As Allies for Children’s Mental Health, Inc. had provided family support and education to 210 families. NAMI-MS had held 14 Parent Support groups in Yazoo City and Jackson. NAMI-MS conducted four Parent to Parent (now termed “NAMI Basics”) classes in FY 2008; 32 individuals participated.

Goal: To develop the family education/support component of the Ideal System model for children with serious emotional disturbance

Objective: To continue to make available funding for family education and family support capabilities.

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Family education/support funding

Indicator: Continuation of funding for family education and family support will be made available by DMH.

Measure: Number of family workshops and training opportunities to be provided and/or sponsored by MS FAA (15)

PI Data Table C1.13	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Family Education Groups		8 family education/support groups available through MS FAA (Hinds, Rankin, Madison, Yazoo, DeSoto, Forrest, Harrison and Hancock); 166 families received services from 8 family support specialists at MS FAA.	8 family education/support groups were available through MS FAA (Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, and Hancock counties)		
# Family Workshops/Training Opportunities Provided/Sponsored	5 family education/support groups available through MS FAA; (Hinds, Madison, Harrison, Desoto, and Jackson counties); MS FAA provided 37 family workshops/training	MS FAA provided 14 family workshops/training opportunities, with 368 participants; five Parent to Parent classes provided by NAMI-MS in 4 regions	MS FAA provided 19 family workshops/training opportunities with 220 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS	15	15

	opportunities; three Visions for Tomorrow classes offered (Regions 9 and 11)				
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Source(s) of

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

Special

Issues: None

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

Funding: Federal and state funds

Availability of Family Education/Support

In FY 2009, Mississippi Families for Children's Mental Health, Inc. (MS FAA) continued to provide a registry of family educators trained by MS FAA to providers upon request.

Youth Education/Support Initiatives

The Mississippi Families as Allies for Children's Mental Health, Inc. (MS FAA) conducts two Youth Leadership Teams, one in Jackson called the "Youth Making a Difference" team. Started in FY 2002, it now 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. The SOC group also formed a Youth Advisory Council (YAC) to give input to the CommUNITY cares project. Members of both 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. In 2005, the Jackson Youth Team hosted its first statewide Youth Summit for over 50 teens. Both Youth Teams are supported by mental health block grant funds and SOC grant funds and in 2008 became chapters affiliated with the National Youth MOVE, a new CMHS initiative.

Since 2003, MS Families as Allies for Children's Mental Health, Inc. (MS FAA) has also conducted the Youth Summer Day Camp for the past five years, 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. MS FAA will continue to provide this summer program, and a similar therapeutic recreation program at the community cares SOC site, with the intent of communicating that the wraparound principle of "no reject, no eject" can be used as a

model to broaden summer program opportunities for youth with special needs. This model gives the teens involved a sense of hope and competency. Based on its Youth Camp experiences thus far, MS FAA believes that these less stressful experiences have a beneficial effect on youths' abilities to cope with their 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, including participation on the State Level Case Review/MAP Team and monitoring of respite services and family education programs.

Case Management, which focuses on coordinating and accessing appropriate services in the community for children with serious emotional disturbance, plays a vital role in preventing and reducing the risk of hospitalization or other out-of-home placement of children.

Discharge Planning - Prior to discharge from the two state psychiatric hospitals, a referral is made to the CMHC in the region to which the discharged child/adolescent is returning, and an appointment is made at the CMHC for the child or youth by hospital staff, unless permission is denied by the parent/guardian. The state psychiatric facilities maintain information indicating where children/adolescents were referred upon discharge from the hospital, and if they were not referred to a CMHC, the reason why and/or where they were referred. The two adolescent inpatient psychiatric units at the state psychiatric hospitals operate schools, which have approved status by the State Department of Education as special schools. Minimum standards (effective July 1, 2002) for community programs that are designed to facilitate continuity of care include the following requirements: DMH-certified providers must have implemented policies and procedures that ensure that, at a minimum, for youth being discharged from inpatient care, residential treatment centers, and therapeutic group homes, (a) the youth (and family member(s) as appropriate) are given an appointment with a mental health professional within two weeks after referral; (b) the youth (and family member(s) as appropriate) are given an appointment with a physician within four weeks after referral; (c) the youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two weeks after referral for community services; (d) inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and, (e) professional staff have been trained and are knowledgeable in the policies and procedures above.

Interagency agreements are also sought with some public schools to enable adolescents who have progressed in their treatment to attend the local school during the day. Transition assistance is also provided. If the child is not in special education, the hospital school develops an individual program plan. Staff maintain contact with the Special Education Program Developer from the school of origin in order to request and share records. Prior to discharge, hospital staff talk with parents and the local school personnel about appropriate services to transition the child back into the community and local school. Other transitioning services include referrals, as appropriate, to GED programs; to school vocation-technical programs; or, Job Corps for vocational training.

Other Activities Leading to Reduction of Hospitalization

As described previously, Making a Plan (MAP) Teams have been established around the state to provide comprehensive planning for those children in need of services as alternatives to

hospitalization and long-term residential treatment placement. MAP Teams target children/youth with serious emotional disturbance who may be placed inappropriately out-of-home, are at immediate risk of being placed out-of-home or who may be returning to the community from inpatient/residential care. Currently, there are 36 MAP Teams statewide. The State Level Case Review/MAP Team reviews cases concerning children/youth demonstrating emotional/behavioral problems for whom adequate treatment cannot be found at the county or local level and for whom no one state agency has been able to secure all the necessary services through its own resources. This state-level team provides another avenue for preventing or reducing hospitalization for youth with more complex or intensive treatment needs who are most at risk for out-of-home placement. As mentioned, the MS Department of Human Services (DHS), which oversees child custody, instructs appropriate staff in its state and local offices that a MAP team review and recommendation may be made prior to authorization of a therapeutic placement by DHS and prior to referral to the State-level Interagency Case Review Team. DHS also direct staff that they should refer children in residential treatment to MAP teams in advance of discharge to determine a wrap-around support services plan needed by the child and caregiver(s) to maintain them in the community. Cooperative efforts between the Department of Mental Health and the Division of Medicaid described previously in the section on Other Systems Development Initiatives will enhance development of the system of care.

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health services

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

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

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

Special Issues: DMH is continuing work on development of the data system to support collection of information for the National Outcome Measures on readmissions to state psychiatric inpatient facilities with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Data was reported through the Uniform Reporting System (URS) tables for FY 2004- FY 2008. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other core indicators over the next three-year period. It should be noted that the current data system does not track individual youth across the community mental health and state hospital systems and although there is some overlap, data are likely to represent two different cohorts. For example,

except for receiving a preadmission screening, not all youth served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Youth Court or Chancery Court systems. DMH continued work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits and to have the capacity to track youth served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH and to improve data integrity. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

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

Action Plan: The state psychiatric hospitals will provide routine reports on the number of readmissions by county to community mental health centers. Other planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will also be continued.

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	.97% Baseline*	1.3%	1.3%	1.25%	1.2%

Numerator: Number of civil readmissions to any state hospital within 30 days	4	5	5	5	4.6
Denominator: Total number of civil discharges in the year	412	384	375	400	390
2. Decreased Rate of Civil Readmissions to state hospitals within 180 days	6.1%**	5.99%	5.6%	6%	5.9%
Numerator: Number of civil readmissions to any state hospital within 180 days	25	23	21	24	23
Denominator: Total number of civil discharges in the year	412	384	375	400	390

*Since this URS table is developmental, FY 2006 and FY 2007 targets indicate continued baseline data collection.

**These preliminary results are also reported in the FY 2007 URS Table 20A and 20B submission; results were modified after review/edits by the National Research Institute (NRI) and the MDMH. *Correction to reporting of FY 2006 data.*

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

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

Special Issues: Piloting of the *Youth Services Survey for Families (YSS-F)* began in FY 2004. DMH had results for all major community services providers for FY 2004. Since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; however, complete data was available later in the process. With consultation and approval from CMHS, the *YSS-F* was not administered in 2005 because of state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. As noted, new items were added to the survey instrument for the first time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC), Center for Health Informatics and Patient Safety to administer the official version of the *YSS-F* to a representative sample of parents of children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 survey was 14%.

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

Action Plan: Case managers will continue to provide linkage and referrals to community resources based on their individual needs and monitoring the child's progress as it relates to the child's service plan in the home, school, and community (e.g. direct services, family education/support, etc.). DMH Division of Children and Youth Services staff will continue to monitor case management service plans for content related to the child/youth's progress in accessing the needed resources or services in the home, school, and community. The community mental health

centers are monitored on an annual basis with a follow-up at six-months to determine the implementation of their plan of correction on any deficiencies noted in the certification /site visit.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding social connectedness	85%	83%	85%	84%	84%
Numerator: Number of families of children/adolescents reporting positively about social connectedness	278	243	259	260	260
Denominator: Total number of family responses regarding social connectedness	326	294	305	308	308

National Outcome Measure (NOM): Improved Level of Functioning (URS Table 9)

Goal: To increase satisfaction of parents/caregivers regarding the functioning of their children youth with serious emotional disturbances

Target: Increase or maintain percentage of parents/caregivers of children with serious emotional disturbance who respond positively about their child's functioning

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

Sources of Information: Results of the *YSS-F* from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system

(funded and certified by DMH).

Special Issues: Implementing many of the same initiatives aimed at improving outcomes and described in the previous National Outcome Measure on outcomes is projected to also impact parents'/caregivers' perception of their children's functioning (described in this National Outcome Measure). Trends in parents'/caregivers' satisfaction with outcomes and with their children's functioning appear similar over time (see Performance Indicator tables). Piloting of the Youth Services Survey for Families (YSS-F) began in FY 2004. DMH had results for all major community services providers for FY 2004; however, since this was the first year of the survey administration, unforeseen problems in the process arose, and only partial results were available by the timeline for FY 2004; however, complete data was available later in the process. With consultation and approval from CMHS, the YSS-F was not administered in 2005 because of state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. As noted, new items were added to the survey instrument for the first time in 2006, during which the official version of the survey recommended by the Center for Mental Health Services was used; therefore, a new baseline of data was established. Since FY 2007, the DMH is has been working with the University of Mississippi Medical Center (UMMC) Center for Health Informatics and Patient Safety to administer the official version of the *YSS-F* to a representative sample of parents of children with serious emotional disturbance receiving services in the public community mental health system and plans to include results in the URS Table 11 submission. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate statewide for the 2008 survey was 14%.

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

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of Families of children/adolescents reporting positively regarding functioning	67%	68%	67%	67%	67%
Numerator: Number of families of children/adolescents reporting positively about functioning	217	200	203	207	207
Denominator: Total number of family responses regarding functioning	326	296	305	309	309

Additional social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (DHS) for families/children who meet eligibility criteria for those specific programs. These services are described in detail under Criterion #3.

Other Support Services are services that typically provide direct reinforcement and/or support for specific behavioral mental health treatment objectives but are not primary direct therapeutic services. In general, these services are coordinated or facilitated by a mental health service professional. Included in this service component would be staff development and training of mental health therapeutic staff and consultation/education of other providers. Also, these services may include (but are not limited to) peer support, mentoring, transportation, and volunteer services. Determining whether or not a service is a support service is based on whether it is necessary to enhance attaining or maintaining direct treatment service objectives.

Private Resources

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 private psychiatric facilities it licenses, reports 220 licensed and/or CON approved inpatient beds in FY 2008 for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units). The MS Department of Mental Health does not collect data from inpatient facilities in the private sector; that information is maintained by the MS State Department of Health, which licenses those facilities.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	33%	33%	33%	33%	
Numerator	1	1	1	1	
Denominator	3	3	3	3	

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

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

Population: Children with serious emotional disturbances

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

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

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

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

Special Issues: As mentioned in the specific objective on therapeutic foster care (described in the Plan), in accordance with federal URS table reporting instructions, the DMH is currently reporting the number of children receiving evidence-based practices in programs receiving funding support from the public mental health agency. Additional youth receive services through therapeutic foster care programs certified, but not funded by the DMH. Youth also receive Multisystemic Therapy (MST) services through a nonprofit program that is certified, but not funded by the DMH and therefore, those data are not included in the EBP table above. DMH does not currently provide funding specifically for Family Functional Therapy; therefore, data is not available on the provision of FFT.

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

Action Plan: The objective to maintain therapeutic foster care services, the EBP that receives DMH funding support and described in the State Plan will be implemented. The Division of Children and Youth Services will also continue to provide technical assistance and to monitor therapeutic foster care programs certified, but not funded by the DMH. Initiatives to promote

implementation of other evidence-based practices for youth and families, such as the Learning Collaboratives for trauma-focused cognitive behavior therapy described in the Plan will also continue. Other local initiatives will also continue; for example, Region 12 CMHC and Region 13 CMHC have organized workforce training in trauma-focused CBT, CBT and Combined Parent Child CBT for all of their children's therapists, and evidence-based practices for youth are being implemented through the local System of Care project in Region 12.

Criterion 2: Mental Health System Data and Epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1) (Criterion 1, previous section.)

Total Number of Children with Serious Emotional Disturbance

National Prevalence

According to final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious emotional disturbance among children and adolescents, (in Federal Register, July 17, 1998), the estimated national prevalence of serious emotional disturbance among children 9-17 years of age is 9-13%. As indicated in the methodology, "if a more stringent definition of impairment is desired than was used (in the methodology) for the estimated range of 9-13%, then the range is from 5-9%. The difference between the two estimates is that the measured level of functional impairment is greater in the second estimate (5-9%) and has been characterized as "extreme functional impairment." The discussion of these two levels also notes that "Children at both levels of impairment are considered to have a "serious emotional disturbance;" however, the group of children falling into the range of 5-9% constitutes a subset of the 9-13%."

The federal methodology operationalizes the federal definition of serious emotional disturbance among children and adolescents, published in 1992. The discussion of the methodology notes that "there are no national epidemiological studies of mental disorders for children and/or adolescents that have been conducted in the United States; therefore, in the absence of a national study, the estimated prevalence rates included in the methodology were derived "from eight, smaller and more localized studies." Currently, "the data are inadequate to estimate prevalence rates for children under the age of nine." A cut-off score of 50 on the children's Global Assessment Scale (CGAS) was used for the level indicating more severe impairment (5-9%); a cut-off score of 60 or lower was used for the level indicating the "less conservative definition of serious emotional disturbance"(9-13%).

Prevalence in Mississippi

As part of the early stages of the planning process under P.L. 99-660, the state based its previous estimates of the size of the population of children and youth with significant mental health needs, including those in need of an array of services, on ranges then available and summarized in the professional literature. Current federal law requires use of standardized methodologies developed

by the Center for Mental Health Services for estimating the incidence and prevalence of serious emotional disturbance among children and adolescents. Thus, in this year's FY 2009 State Plan, Mississippi will utilize 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 explained above. Estimates in the 2010 State Plan were updated from Uniform Reporting System (URS) Table 1: Estimated number of children and adolescents, age 9-17, with serious emotional disturbances by state, 2008 prepared by the National Association of Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS).

In the methodology, prevalence estimates were adjusted for socio-economic differences across states. Given Mississippi's relatively high poverty rate when compared to other states, the estimated prevalence ranges for the state (adjusted for poverty) were on the higher end of the ranges in the 7/17/98 Federal Register. The estimated number of children, ages 9 through 17 years in Mississippi in 2008 is 378,753* Mississippi remains in the group of states with the highest poverty rate (32.6% age 5-17 in poverty, based on 2007 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 2008 are as follows:

- (1) Within the broad group (9-13%), Mississippi's estimated prevalence range for children and adolescents, ages 9-17 years,* is 11-13% or from 41,663 – 49,238
- (2) Within the more severe group (5-9%), Mississippi's estimated prevalence range for children and adolescents, ages 9-17 years,* is 7-9% or from 26,513 – 34,088

As pointed out in the methodology, there are limitations to these estimated prevalence ranges, including the "modest" size of the studies from which these estimates were derived; variation in the population, instruments, methodology and diagnostic systems across the studies; inadequate data on which to base estimates of prevalence for children under nine; and, inadequate data from which to determine potential differences related to race or ethnicity or whether or not the youth lived in urban or rural areas. As noted in the discussion of the estimation methodology in the Federal Register, "(t)he group of technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that "(I)n the future, incidence and prevalence data will be collected." As explained in the section that follows on the population of children targeted in the FY2010 Plan, the upper age limit in the definition for children with serious emotional disturbances was extended (beginning in the FY 2003 Plan) to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. The change in Mississippi's definition was made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. Although this constitutes a difference from the federal definition for children with serious emotional disturbance, which defines children as being up to 18 years, it is recognized in the 5/20/93 Federal Register that some states extend this age range as high as to persons less than age 22. In such cases, it was also noted in the Federal Register (5/20/93), that states should provide separate

estimates for persons below age 18 and for persons aged 18 to 22. Since Mississippi has extended its age range for children with SED up to age 21 years, and kept its lower age range for adults with serious mental illness at 18 years, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (133,693**), yielding an estimated prevalence of 12,300 in this transition age group.

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

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

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- Goal:** To include in the State Plan a current estimate of the incidence and prevalence in the State of serious emotional disturbance among children, in accordance with federal methodology.
- Objective:** To include in the State Plan an estimate of the prevalence of serious emotional disturbance among children in the state.
- Population:** Children with serious emotional disturbance
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Mental Health System Data Epidemiology
- Indicator:** Utilization of revised estimated prevalence ranges of serious emotional disturbance among children and adolescents (9-17 years of age) in the FY 2010 State Plan (as described above), based on the final estimation methodology for children and adolescents with serious emotional disturbance published in the July 17, 1998 Federal Register.
- Measure:** Inclusion of prevalence estimates derived using federal methodology in the FY 2010 State Plan.
- Source of Information:** Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and from the Survey and Analysis Branch at the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.
- Special Issues:** There are limitations to the interpretations of this prevalence estimate, explained above.

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

Funding: Federal and state funds

Quantitative Targets: Number of Children To Be Served

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

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

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

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

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

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

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

DMH has continued work in FY 2009 on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Current plans call for reporting of unduplicated data by the end of FY 2010. As this system continues to be implemented within the FY 2009-2010 time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed. DMH continued work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 2. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions and to address other data integrity issues also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: This objective provides an estimate of the service capacity of the public mental health system to provide services to children with emotional disturbance/mental illness in FY 2010.

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
Total persons under 18 years served in public mental health system*	30,689* Baseline	30,433*	31,189	30,275	30,000

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

** These results are also reported in the FY 2008 URS Tables 2A and 2 B submission; results may be modified after review/edits by the National Research Institute (NRI) and the MDMH.

Target or Priority Population to be Served Under the State Plan

Definition of Children with Serious Emotional Disturbance:

As described previously, beginning in the FY 2003 State Plan and in the current Mississippi Division of Medicaid Community Mental Health Manual, the upper age limit in the definition for children with serious emotional disturbances has been extended to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. This is a difference from the federal definition for children, which defines children as being up to 18 years. The change in Mississippi's definition has been made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences.

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

Community-based Services for Youth with Serious Emotional Disturbances

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

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

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

Population: Children with serious emotional disturbance

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in community mental health services

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

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

PI Data Table C2.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# SED Served	29,531	28,939	29,269	21,000	28,500

Source(s) of .

Information: Annual State Plan survey; community mental health service provider data.

Special

Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented within the FY 2009-2010 time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

Significance: This objective provides an estimate of the service capacity of the public community mental health system to provide services to children with serious emotional disturbance in FY 2010, the priority population served by the DMH Division of Children and Youth Services and the population eligible for services funded by the CMHS Block Grant.

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

The management of children's community mental health services data is also addressed in the information management objective described in detail under Criterion #5.

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

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) will continue to partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) for a statewide Anti-Stigma Campaign, "What a Difference a Friend Makes" until October, 2009.

In October 2009, DMH and the statewide Anti-Stigma Committee will launch a campaign specific to Mississippi entitled, "Think Again." The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. It will continue to show young adults how to support their friends who are living with mental health problems. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children's Services and Adult Services State Plans. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign.

DMH is conducting a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi's Anti-Stigma Campaign efforts have joined forces with DMH's Youth Suicide Prevention Campaign, "Shatter the Silence." DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, and the distribution of flyers and brochures on campus. DMH incorporates the message of supporting your friends, dispelling the stigma associated with mental health problems and youth suicide in all presentations and handouts.

Goal: To address the stigma associated with mental illness through a three-year anti-stigma campaign.

Objective: To lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the Anti-stigma campaign.

Population: Adults and children

Brief Name: Anti-Stigma Campaign – Second Year: "What a Difference a Friend Makes"

Indicator: To reach 200,000 individuals during FY 2010

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

interviews and presentations.

MH Transformation PI Data Table	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2006 Plan	Not an objective in the FY 2007 Plan	1.3 million reached	200,000	200,000

Source(s) of

Information: Media and educational presentation tracking data maintained by DMH Director of Public Information.

Special

Issues: Activities to plan and kick-off the first year of the three-year anti-stigma campaign began in FY 2007, therefore, the different themes will overlap the fiscal year(s) addressed in the State Plan. The anti-stigma campaign has partnered with DMH's youth suicide prevention campaign for presentations and information distributed to young adults.

Significance: Although youth and young adults, 18-25 years of age, are almost double that of the general population, young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on. The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness.

Funding: Federal, State and/or local funds

As described in detail under Criterion #3 and under Criterion #5, DMH Division of Children/Youth Services staff continues to participate regularly in interagency meetings, conferences and other training events that provide opportunities for increasing awareness across the service system of available children's mental health services. The Division of Children and Youth Services will also continue to disseminate educational materials to the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances. The directory is available through the DMH agency website. As of March 2009, 390 CYS resource directories had been disseminated at conferences or meetings or to individuals, including: A-team Coordinators; MAP Team Coordinators; Piney Woods Health & Resource Fair; CMHC Regions 8, 9, 11, 12 and 13; MS Association of Pediatricians, Mississippi Health Summit, Clinton Public Schools, Pre-evaluation Screening training participants, Mississippi State Hospital, foster care and adoptive parents, Mt. Nebo Church Health Fair, participants at the MS Counselors' Association training, and Mississippi Families As Allies for Children's Mental Health, Inc.

- Goal:** To increase public awareness/knowledge about serious emotional disturbance among children and services they need.
- Objective:** To provide general information/education about children/adolescents “at risk” for or with serious emotional disturbance and about the system of care model (targeting the community at-large, as well as service providers).
- Population:** Children and youth with serious emotional disturbance.
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** Information dissemination – general
- Indicator:** Continued production and dissemination of *the DMH Division of Children and Youth Resource Directory* and other relevant public education material, made available as needed. Participation in/presentations by DMH Children and Youth Services staff at meetings at which public information is provided, as such opportunities are available.
- Measure:** Dissemination of directory/other public education material and participation of DMH Children and Youth Services staff in meetings/presentations will be documented.
- Source(s) of Information:** Educational material dissemination documented on monthly staffing forms.
- Special Issues:** None
- Significance:** Availability of current information about children’s mental health services through printed material and education by DMH staff is a basic component of ongoing outreach services.
- Funding:** State funds, CMHS block grant, federal discretionary and other grant funds as available.

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

Community mental health centers continued to provide information to schools on identification of youth at risk for and with serious emotional disturbances or mental illness and on resources to address the needs of those youth. In FY 2008, informational materials and technical assistance were provided to 897 local schools by community mental health centers. The DMH Division of Children/Youth Services will continue to track the number of schools to which information is made available.

- Objective:** To continue to provide information to schools on recognizing those children and youth most at risk for having a serious emotional disturbance or mental illness and

on resources available across the state, including services provided by CMHCs.

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Information/assistance to schools

Indicator: Availability of informational materials and technical assistance to local school districts and other individuals/entities by CMHCs, upon request.

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

Source(s) of Information: Annual State Plan Survey

Special

Issues: Tracking of the number of schools to which CMHCs provide educational materials/technical assistance will continue to be a data item on the Annual State Plan Survey in FY 2009. The number of schools requesting/receiving this information can vary across years; therefore, no specific target will be established. If a significant decrease in the number tracked across years is observed, DMH Division of Children/Youth Services will investigate the trend and implement technical assistance to address the issue.

Significance: Availability of informational materials and technical assistance from CMHCs strengthens outreach and service collaboration efforts with local schools.

Funding: Federal, state, and/or local

Criterion 3: Children's Services - in the case of children with serious emotional disturbance, the plan-

- **Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include: social services; educational services, including services provided under the Individuals with Disabilities Education Act; juvenile justice services, substance abuse services; and, health and mental health services.**
- **Establishes defined geographic area for the provision of the services of such system.**

Provisions for an Integrated Service System

State Agency/Office Partners in the System of Care: In Mississippi, coordination of children's services is a cooperative effort across major child and family service agencies. Responsible state agencies are as follows:

State Children’s Health Insurance Program, MS Health Benefits: Division of Medicaid, Office of the Governor (lead agency)

Mental Health and Substance Abuse Services for Children: Mississippi Department of Mental Health, Bureau of Mental Health, Bureau of Community Services, Division of Children/Youth Services and Bureau of Alcohol and Drug Abuse Services

Social Services/Protective Services: Mississippi Department of Human Services, Division of Family and Children’s Services

Juvenile Justice Services: Mississippi Department of Human Services, Division of Youth Services; Mississippi Office of the Attorney General; Mississippi Department of Public Safety, Office of Justice Programs; Mississippi Youth Court Judges Association

Educational Services: Mississippi State Department of Education

Dental/Health Services: Mississippi State Department of Health and Division of Medicaid

Rehabilitation Services: Mississippi Department of Rehabilitation Services.

The statewide nonprofit, non-governmental organization that is primarily involved in family education/support and advocacy for children with serious emotional disturbances and their families is Mississippi Families As Allies for Children’s Mental Health, Inc.

The **geographic areas for the provision of public community mental health services for children** and adults is 15 mental health/mental retardation regions, which include the 82 counties in the state.

Community mental health block grant funds for FY 2010 will not be expended to provide any services other than in support of comprehensive community mental health services. (Projected expenditures are described in detail under Criterion 5 in this Plan that follows.)

Mental Health Transformation Activities: Improving Coordination of Care among Multiple Systems and Involving Families Fully in Orienting the Mental Health System to Recovery (NFC Goals 2.2 and 2.3)

Interagency Collaboration Initiatives:

Facilitation of interagency collaboration and coordination among child and family service agencies and families of children with serious emotional disturbance first developed through earlier federal grant projects, including CASSP initiatives and later also supported by a CMHS Local System of Care Development grant, COMPASS in Hinds and Rankin counties, MS, has been a major focus of the Department, the Division of Children and Youth Services and the Planning Council over time. Interagency collaboration and coordination activities exist at the

state level and in various local and regional areas. These activities encompass needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives are:

The Interagency Coordinating Council for Children and Youth (ICCCY): As mentioned under Criterion 1, legislation passed in 2001 was extended by Senate Bill 2991, continuing authorization of a state-level Interagency Coordinating Council for Children and Youth (ICCCY) through 2010. The legislation called for the establishment of an Executive Level Interagency Coordination Council for Children and Youth, on which the heads of the state agencies for education, health, human services, mental health, rehabilitation services, Medicaid, and the family organization, MS Families As Allies for Children's Mental Health, Inc., participate. The act further established a mid-level Interagency System of Care Council (ISCC) to perform certain functions and advise the Interagency Coordinating Council and to establish a statewide system of local MAP teams. In 2002, the ISCC developed an Interagency Plan/Report that was presented to and approved by the executive level ICCCY. Periodic reports of progress on objectives and recommendations have been made since that time to the ICCCY. This System of Care document contained recommendations related to the specific objectives contained in the authorization legislation and was developed by the mid-management ISCC under the leadership of the DMH Director of the Division of Children and Youth Services. As of March 2009, the DMH Executive Director continued to serve as chairperson of the ICCCY, and the Director of the DMH Division of Children and Youth Services served as chairperson of the ISCC. The ISCC met on October 8, 2008, to discuss the ICCCY meeting agenda, Interagency Agreement Agency updates, and an Action Plan. The ISCC also met in December 2008 at a networking luncheon with the MAP Team Coordinators and on February 4, 2009 to discuss the upcoming ICCCY meeting, new membership, legislation, agency updates, cross-training efforts, and to develop a plan for consultation on the new/revised ICCCY legislation for 2010. The ICCCY met on October 10, 2008 and was updated on the System of Care Project, MYPAC, FASD project, Youth Suicide Prevention efforts and family involvement. The ICCCY also met on April 24, 2009; cash contributions, the current fiscal situation, recovery funds, and flexible funds were discussed. The members voted on supporting the reauthorization of the Mississippi System of Care legislation in January 2010, since it will sunset June 30, 2010. The ICCCY received updates on the MAP teams, the ISCC, and the System of Care Study. The MAP teams from Region 7 then conducted a mock MAP team meeting to illustrate how they are working with typical cases.

Goal: Facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels) in development of a system of care for children with serious emotional disturbance.

Objective: To provide mental health representation on the Executive Level Interagency Coordination Council for Children and Youth and the mid-management level Interagency System of Care Council, as required by recent legislation.

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Interagency Coordination Council Participation (ICCCY and ISCC)

Indicator: Continued participation by the DMH representatives on the Executive Level ICCCY and the mid-level Interagency System of Care Council, in accordance with Senate Bill 2991 and continued activities by both Councils in supporting and expanding the systems of care values and principles across the state.

Measure: Minutes of meetings and related documentation of attendance by DMH representatives at meetings scheduled in FY 2010

Source(s) of

Information: Minutes of the ICCCY and the Division of Children and Youth Services Monthly Calendar and minutes of the mid-level Interagency System of Care Council and revised strategic plan.

Special

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

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

Funding: State and federal

State-Level Interagency Case Review MAP Team: 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. Agencies represented on Mississippi’s team include the Department of Mental Health; the Department of Human Services; the Office of the Governor, Division of Medicaid; the Attorney General’s Office; the Mississippi Department of Health; the Mississippi Department of Education and the Department of Rehabilitation Services. MS Families As Allies for Children’s Mental Health also has a representative on the team. 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 those “most difficult to serve” youth with serious emotional disturbance 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. There typically have been numerous interruptions in delivery of services across a variety of attempted services due to frequent moves, failure to show for treatment or for unknown reasons. Cases reviewed by the State-Level Interagency Case Review/MAP Team must be referred from the local level. The state-level team identifies what has been tried and the services that have been used; it identifies what is available that may meet needs and what services/supports have not been utilized. 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. As local, community-level Making a Plan (MAP) teams continue to be developed in local community mental health regions, linkages with the State-Level Interagency Case Review/MAP Team facilitate assistance to local MAP teams as needed. As of March 2009, the State Level Case Review Team had reviewed 11 cases, of which four cases were of youth who were diagnosed sexually reactive and also diagnosed with a serious emotional disturbance. A meeting was held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Operation of State-Level Interagency Case Review Team and support

Indicator: Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases and continue to provide a social work intern for the facilitation and follow-up of cases reviewed. (Documentation of meetings maintained).

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

Source(s) of

Information: Monthly Division Activities Report and State Level Case Review Team Staffing forms.

Special

Issues: None

Significance: Continuation of the State-Level Case Review Team is consistent with a provision in the Mental Health Reform Act of 1997 allowing for interagency agreements at the local level, providing another level of interagency review and problem-solving as a resource to local teams that are unable to/lack resources to address the needs of some youth with particularly severe or complex issues.

Funding: Local, state, and/or federal funds for salaries of staff from represented agencies/programs; funds will also be available when needed for family members' travel expenses.

The State Level Case Review/MAP Team is facilitated by the Division Director of Children and Youth Services, an assigned Division staff, and by a social work student from a local university assigned to the Division for internship. In FY 2009, the DMH will continue to make available funding for the State Level Interagency Case Review/MAP Team to distribute for services for children/youth reviewed by that team and for which funding and/or other resources do not appear accessible at the local level, including youth who reside in counties without MAP Teams. Those youth from communities in which there is no local MAP team with funding will have priority. The state-level team will facilitate a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: State-Level interagency team funded

Indicator: Availability of funding from DMH Division of Children and Youth Services to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team.

Measure: Availability of funding and the number of children served using this funding for wraparound services

Source(s) of

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

Special

Issues: None

Significance: This is the first flexible funding (other than existing resources) available to the state-level team for providing services.

Funding: Federal (CMHS Block Grant)

Making A Plan (MAP) Teams

The MAP teams employ a wrap-around 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, and local school staff. Other providers of formal or

informal supports, which vary from team to team, also might participate in the planning or service implementation process. Examples of providers of community supports include youth leaders, ministers or other representatives of children/youth family service organizations in a given community. Thus, implementation of the plan might involve accessing a variety of informal or formal resources in the community and maximizing use of a variety of funding sources.

Also, as mentioned, if a MAP team is available in the county, the Department of Human Services continues to encourage appropriate state and local workers in the agency to present cases to the MAP team of children with serious emotional disturbance in DHS custody and/or receiving DHS services who are being considered for placement in or who are in need of a discharge plan from psychiatric inpatient or long-term residential care and/or prior to referral to the State Level Interagency Case Review Team.

DMH Division of Children and Youth Services coordinates regular meetings with MAP team coordinators to which representatives from the state hospitals child/adolescent units and the Department of Human Services representatives are invited. As of March 2009, the Division of Children and Youth Services Director had coordinated three statewide meetings with local MAP Team Coordinators. The Department of Human Services, Division of Youth Services Adolescent "A" Team Coordinators attended one meeting, held in February 2009. The following topics were discussed throughout the year thus far: the Fetal Alcohol Spectrum Disorders project, MYPAC, case reviews, the Concept Mapping Completeness survey results, MAP Team expansion, youth suicide prevention activities, and juvenile justice. Technical assistance was provided to MAP Teams in CMHC regions 1, 2, 5, 6, 8, 9, and 14. Technical assistance regarding the expansion of MAP Teams was provided to Regions 2, 9 and 11.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Technical assistance provided for MAP teams

Indicator: Provision of MAP team local coordinators meetings for networking among MAP teams.

Measure: Number of meetings of MAP Coordinators led by a designated Children/Youth Services staff member (at least four) and number of local MAP team meetings attended by DMH representatives.

Source(s) of

Information: Monthly Division Activities Report and minutes of local MAP team meeting.

Special

Issues: None

Significance: Revisions to the DMH Minimum Standards require each CMHC region to participate in or establish one MAP team. Regular meetings with DMH staff and other MAP team coordinators across the state aid in local interagency development through group discussions of barriers, strengths, procedures and other related issues on local infrastructure.

Funding: Federal, state and/or local

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. As mentioned previously, DMH made available flexible funds from its FY 2004 CMHS Block Grant increase to an additional specialized MAP team (in Region 8). In FY 2009, the DMH continued to make available flexible funds to at least one MAP team in each of the 15 CMHC regions to purchase critical services and/or supports identified as needed, but otherwise not funded, to keep a child with SED from unnecessary or inappropriate institutional placement; Region 8 received additional funding for children with fetal alcohol spectrum disorders. A total of 36 MAP teams continued to operate statewide, with access to flexible funds through the 15 CMHCs and Catholic Charities.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: MAP team funding

Indicator: Availability of funding through DMH for MAP teams.

Measure: Number of MAP teams that receive or have access to flexible funding through DMH. (Total of 35 teams)

PI Data Table C3.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# MAP Teams with Flexible Funding	16	16	16		
# MAP Teams with access to flexible funding				35	35

Source(s) of

Information: Documentation of grant awards; Monthly MAP team reports; monthly cash

requests.

Special

Issues: Additional information from the MAP teams tracked includes services purchased and the number of youth staffed/served.

Significance: The ultimate goal of this initiative is to expand the availability of these teams statewide.

Funding: State and federal

The DMH Division of Children and Youth Services continues to participate in multiple efforts to enhance interagency collaboration across the system of care at the state and local levels. As of March 2009, the DMH Division of Children and Youth Services staff was participating on the following interagency committees and workgroups: the Interagency Coordinating Council for Children and Youth (ICCCY), the State Level Interagency Case Review Team, the DHS Citizen Review Board, MS Alliance for Health (MASH) Conference Planning Committee, Interagency System of Care Council, *Lookin' to the Future* Conference Planning Committee, Advisory Council for FASD, MS Association of Drug Court Professionals (MADCP) Drug Court Conference Committee, American Association of Pediatrics Mental Health Task Force, Underage Drinking Task Force, Prevent Child Abuse Advisory Council, Multicultural Task Force, Youth Suicide Prevention Advisory Council, "Cradle to Prison Pipeline" Summit Planning Committee (Children's Defense Fund), the Core Committee, Cultural & Linguistic Committee and Sustainability Committee of community cares (System of Care project), and the Case Management Task Force. DMH Division of Children and Youth Services staff also attend meetings of the Children's Services Task Force of the Mississippi State Mental Health Planning and Advisory Council.

Department of Mental Health staff will continue to participate in a variety of state-level interagency collaboration activities and will provide support for interagency collaboration at the local level in the 15 CMHC regions. These efforts will 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. Local infrastructure building strategies will continue to be addressed with audiences of CMHC children's staff, as well as families and representatives of county offices of DHS Family and Children's Services (Child Welfare), Youth Services (Juvenile Justice); local school districts; health; and other key community providers or leaders when identified.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Participation on interagency committees

Indicator: Participation of DMH Children/Youth Services staff on state-level interagency councils or committees.

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

Source(s) of Information: Monthly Division Activities Report

Special Issues: None

Significance: Interagency collaboration at the state and local levels in planning and training is necessary to develop a more integrated system and to improve continuity of care.

Funding: State funds, local funds, other federal discretionary, and private foundation grant funds as available.

In FY 2010, RFP guidelines for applicants for children and youth services funds (federal or state) will continue to require participation in an existing local level MAP team for children and youth with serious behavioral and emotional disorders who are most at-risk for being placed in appropriate out-of-home/community residential or inpatient facilities or to establish such a team if one does not exist for this population in the respective service area. (CMHC case management providers must also provide this as part of meeting the standards for case management services.)

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Participation in local MAP teams

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

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

Source(s) of

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

Special

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

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

Funding: Local, State, and Federal funds

Additional interagency initiatives involving partners in the system of care are described in this section. DMH Division of Children and Youth will continue to make available information to relevant children's service providers across the system of care on training opportunities and technical assistance pertaining to their area(s) of service, such as through continued support of an annual statewide conference addressing the system of care. (See Criterion #5.) Some of the training/technical assistance may be provided by DMH Division of Children and Youth Services staff, with some provided by other social or health services providers, university faculty, and/or family members/educators.

Health and Mental Health Initiatives

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

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

Substance Abuse Initiatives

As indicated under Criterion 1, substance abuse services are also administered by the MS Department of Mental Health through its Bureau of Alcohol and Drug Abuse, which is located in the same Department as the Division of Children and Youth Services. This organizational structure facilitates coordination of mental health and substance abuse services, both at the state and local levels. For example, the community-based residential treatment programs for adolescents with substance abuse problems also serve adolescents with dual problems of substance abuse and mental illness. Also, at the local level, the regional community mental health centers are the primary providers for both community mental health and outpatient substance abuse treatment for youth. In recent years, as described previously under Criterion #1 (Special Populations), the Bureau of Community Services and the Bureau of Alcohol and Drug Abuse have increased targeted efforts to better identify youth with emotional disturbances who might also have substance abuse treatment needs. Refer to Criterion 1 for specific objectives related to

coordination across systems to provide mental health and substance abuse services to youth with a dual diagnosis. Efforts will continue in identification of more children and youth in community-based services who are initially identified only as having a serious emotional disturbance who also may have a substance abuse diagnosis. Also, as mentioned previously, the Directors of the Division of Children and Youth Services and the Bureau of Alcohol and Drug Abuse Services continue to collaborate on fetal alcohol spectrum disorder issues.

Social Services Initiatives

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

Specific social services are available to children with serious emotional disturbance administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The MDHS Division of Family and Children's Services provides child protective services, child abuse/neglect prevention, family preservation/support, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure and case management. The MDHS Division of Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program (TWP), Supplemental Nutrition Assistance Program (SNP), SNAP Nutrition Education and the "Just Wait" Abstinence Education program. The MDHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, A-Teams coordination, and oversees the state training schools. The MDHS Division of Child Support provides child support location and enforcement services, educational parenting programs, mediation, counseling programs, monitored and supervised visitations, and pro-se workshops and non-custodial visitation programs. The MDHS Office for Children and Youth provides certificates for child care services for TANF and Transitional Child Care (TCC) clients, children in protective services or foster care, as well as low income eligible working parent(s) or parent(s) in an approved full-time education or training program. The MDHS Division of Aging and Adult Services provides resources to the elderly and disabled population through the system of Area Agencies on Aging. The ADRC/Mississippi Get Help provides a website for services and resources available throughout the state. One phone call provides access to trained Information and Assistance Specialists, who help with referrals to agencies and/or services, eligibility information, application assistance to apply for services, long-term care options counseling and follow-up.. The MDHS Division of Community Services provides services such as homeless resource referrals low income utility assistance, weatherization of eligible clients' homes and the Fatherhood Initiative Program. Through Community Services Block Grant (CSBG), the Division of Community Services offers health and

nutrition programs, transportation assistance, education assistance, income management, housing and employment assistance.

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

A free appropriate public education (FAPE) must be available to all children residing in the 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).

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

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

Any related service required by a student to enable him or her to benefit from their special education services and any transition services determined appropriate by the IEP Committee must be provided at no cost to the parent. These related services include, but are not limited to: communication services, counseling services, physical therapy, occupational therapy, behavior interventions, assistive technology evaluations and devices, parent education and training, adapted physical education and transportation. All districts in the State must provide all services as determined by the IEP Committee.

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

Committee. The IEP must also have a desired post-school outcome statement. This statement should address areas of post-school activities/goals, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living and/or community participation.

Other Educational Services and Initiatives

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

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

As mentioned under Criterion 1, the Division of Children and Youth Services targets many of its outreach efforts to school settings through provision of educational materials and presentations. A major area of growth in the system of care has been the development through community mental health centers of school-based outpatient sites and day treatment statewide, which is also the primary strategy for increasing accessibility of services for youth in rural areas. Objectives related to expanding school-based community mental health services are located under Criterion 1 and Criterion 4. Representatives of the MDE are participants in state-level interagency groups described previously in this section, and local school district representatives are participants on local Making a Plan teams. Community mental health centers also provide training on children's mental health services to local teachers.

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

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

Special Issues: In addition to the data being based on self-report, the relatively low number of total responses to this survey item compared to the number of responses to other items on the survey, and the relatively high number of "not applicable/no responses" (105 in 2008) excluded from the total responses to this item in calculating percentage of improvement should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of "branching" questions added to the end of the original *YSS-S* survey instrument to gather information on this NOM), which may be confusing to some respondents.

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

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

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of Families of children/adolescents reporting improvement in child's school attendance	48.2%	54.2%	44.3%	48%	48%
Numerator: Number of families of children/adolescents reporting improvement in child's school attendance (both new and continuing clients)	119	89	78	95	95
Denominator: Total number (including Not Available) (new and continuing clients combined)	247	164	176	196	196

Mental Health Transformation Activities: Juvenile Justice Initiatives

Adolescent Offender Programs

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

DMH Division of Children and Youth Services staff has been working with the Department of Human Services, Division of Youth Services to implement a substance abuse treatment curriculum in the training schools and in the Adolescent Offender Programs. DMH will continue to encourage and support continuation of existing programs, as well as expansion of the programs

to other regions of the state in FY 2009.

Juvenile Justice Interagency Training

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system

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

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

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

Special Issues: In addition to the data being based on self-report, the low number of total responses to this survey item (12 in 2008) compared to the number of responses to other items on the survey should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of “branching” questions added to the end of the original *YSS-S* survey instrument to gather information on this

NOM), which may be confusing to some respondents, as well as to some parents'/caregivers' reluctance to respond to questions about their child's involvement in the justice system.

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

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

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of children/adolescents Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	62	57	33	46	46
Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	18	8	4	6	6
Denominator: Total number of children/adolescents arrested in T1 (new and continuing clients combined)	29	14	12	13	13

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

In recent years, 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.

Transitional Services Task Force: A task force formed to better identify and plan to assess needs of youth, age 18 to 25 years, continued its interagency initiatives in FY 2009 and will continue in FY 2010. The task force began meeting in July 2003, further defining the direction for identifying and serving youth with serious emotional disturbances or mental illness in this age group. The group has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14. This has been identified as an age at which children/youth begin to fall out of the system. Through learning about the Transitional-Outreach program, which is funded by the Department of Mental Health, the group has been able to identify ways to address the needs of the transition-age youth in an intensive case management model that utilizes the wraparound approach. In FY 2005, coordination of the Transitional Services Task Force was assigned to the DMH Division of Children and Youth Services staff member who works specifically with those programs that serve transition-age youth. 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 group has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. Potential goals discussed included development of a resource/service directory to assist parents and professionals involved with this age group and strategies for increasing collaboration specifically targeting the transition age group.

As of March 2009, the Transitional Age Task Force, which was chaired by a DMH Division of Children and Youth Services staff member, met in November 2008 and in May 2009 to continue to develop strategies for increasing appropriate service options for transitional age youth (12-24 years) and to identify gaps and issues in the existing system for serving transitional age youth (e.g., Medicaid eligibility, housing, substance use, education, rehabilitation, etc.).

In addition, transitional-age youth are included as a target population addressed by the ICCCY and to be served by MAP teams. (See Criterion #1 in the Adult Services Plan for more detailed information on this three-year project.) Also, the Transition Services Coordinator for the MS Department of Rehabilitation Services has continued to serve on the State-level Case Review Team.

Additionally, as explained under Criterion #2, changes made in prior years to the definition of children with serious emotional disturbance in this Plan and in the Medicaid Mental Health (CMH) Provider Policy Manual included extending the upper age limit to up to 21 years, while the lower age range for adults with serious mental illness remains at 18 years. This change allows

more flexibility in individualization of services for youth 18 to 21 years, including access to services in either the child system or the adult system, depending on the strengths, needs, and preferences of the individual young person.

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

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Transitional services planning

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

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

Source(s) of

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

Special

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

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

Funding: Federal and state

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

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 18 to 21 years. Part of Mississippi's FY 2000 CMHS Block Grant increase was used to provide an additional clinical coordinator to partner with an existing coordinator to facilitate and enhance services across all therapeutic group homes operated by one provider. As of March 2009, DMH continued to provide funding for Rowland Home and Harden House (operated by Southern Christian Services), two group home programs that had served 26 youth thus far in FY 2009. Additionally, DMH continued funding for two supported living programs for youth in the transitional age group (16-

21 years of age), *Transitional Outreach Programs (TOPs)*, operated by Pine Belt Mental Healthcare Resources and Mississippi Children's Home Society/CARES.

Objective: To 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).

Population: Children with serious emotional disturbance

Criterion: Children's Services

Brief Name: Transitional residential and supported living program funding

Indicator: Continued funding of two transitional living services group homes and two supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.

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

PI Data Table C3.5	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Transitional Living Homes/ Supported Living Programs Funded	2* *Target modified in FY 2006.	2	Two group home programs served 40 youth, and two supported living programs served 95 youth	4 transitional living programs	Four transitional living programs (two group homes and two supported living programs)

Source(s) of

Information: Grant awards to continue funding to the targeted transitional living services/supported living programs.

Special

Issues: None

Significance: This funding supports the provision of mental health services needed by these youth that facilitates their transition to a more independent setting.

Funding: Federal, state, local funds

As mentioned previously, the five-year grant supporting a transition from school to work project led by the Mississippi Department of Rehabilitation Services (Model Youth Transition Innovation (MYTI), ended in 2008; however, a no-cost extension was approved. Sustainability efforts between partners are being coordinated, and all plans will be in place before September 2009.

Criterion 4: Targeted Services to Rural and Homeless Populations-

- **Describes States' outreach to and services for individuals who are homeless**
- **Describes how community-based services will be provided to individuals residing in rural areas.**

Outreach to and Services for Youth/Families Who Are Homeless

During the first part of FY 2009, specialized services for homeless/runaway youth ~~are currently~~ were provided through Our House, operated in Jackson by Catholic Charities, Inc. Our House was designed to provide a safe place or environment and focuses on eventually returning youth to their homes. "Project Safe Place," an outreach service of Our House, provides a network of 34 "Safe Place" sites where youth can go for immediate help, and outreach on 50 public transportation buses throughout the Jackson community. As of March 2009, the DMH continued to provide at the 50% level of funding for the SAFE Place coordinator salary. Our House Emergency Shelter reported having contact with 56 youth by mid-year. Adult volunteers who are trained in crisis intervention offered assistance and transportation to the shelter for youth who could not return home. The shelter was closed March 31, 2009, and the Our House Residential Program has transitioned from a residential-based program to the community host homes model. Youth being served the last weeks of the program returned to their home. The purpose of the Catholic Charities, Inc. Host Home Program (HHP) is to provide shelter, counseling and prevention services for runaway and homeless youth. The shelter service will be provided using the Host Home model, with host homes recruited throughout the tri-county metro area. The HHP will provide 24-hour service and accessibility to youth who are eligible for services, while maintaining strict confidentiality. Youth and families will receive individual and family counseling, case management and service linkage, in addition to access to transportation services. Professional staff will work collaboratively with the school system to enhance academic endeavors. The HHP will begin developing a plan for aftercare services upon admission to the program. Each plan will include an attempt to contact the parents or legal guardians to facilitate a safe return of the youth to the family. If family reunification is not feasible then alternative permanent placements for youth will be sought. Linking with the Catholic Charities, Inc. Immigration Clinic, the HHP will reach out to underserved youth in crisis in the immigrant population, especially Hispanic residents in the Canton, MS, area. The overall goal of the HHP is to reunite youth with their families or to secure appropriate permanent placements that can move these adolescents toward successful independence.

The Domestic Violence Center, also operated by Catholic Charities, Inc. in Jackson, by the nature of its program, provides additional outreach services to women and children who are already homeless or potentially homeless because of domestic violence. Additionally, this program is linked to a network of crisis and treatment services, also operated by Catholic Charities.

Similarly, the Gulf Coast Women’s Center, which operates a crisis intervention program for children and families (with funding from the DMH) as a component of a domestic violence program, also provides outreach to homeless or potentially homeless women and children. This program also provides care coordination services such as making referrals, securing housing, medical/dental care, and educational services to children and youth with serious emotional disturbances or youth at risk for emotional illness entering the center. In FY 2003, the Gulf Coast Women’s Center also began receiving PATH grant funds (federal grant for homeless individuals with mental illness) to address the needs of the women served by the center. (See Criterion #4, Adult Services Plan). As of March 2009, the Gulf Coast Women’s Center reported having served 44 youth in 35 families.

Beginning in FY 2000, funds were made available to Region 13 CMHC (Gulf Coast Mental Health Center) to provide intensive crisis intervention and support services with an emergency shelter for abused/neglected children/youth and training to staff of the shelter. Gulf Coast Mental Health Center, provides consultation and in-service training to the shelter staff, crisis intervention available on a 24-hour basis, individual, group and family therapy to the children admitted to the shelter. As of March 2009, Region 13 had provided services to 44 children from the local shelter for abused/neglected children.

The Division of Children and Youth Services has continued collaboration with these specialized programs and plans to continue helping support the outreach/crisis intervention capacity of these programs and will continue to be available to three currently funded programs to enhance their outreach and service initiatives to youth who are homeless/potentially homeless in FY 2010.

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

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

Population: Children with Serious Emotional Disturbance

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Outreach to homeless/runaway youth

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

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

PI Data Table C4.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Homeless/ Runaway Youth with	215 served	177	163	90	45

SED Served					
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Source(s) of**Information:** Program grant

Special Issues: As of May 2009, no youth were being served, as staff have transitioned to the Catholic Charities, Inc. main office and the shelter building has been closed; however, the program projects beginning to serve youth in July 2009. Staff have received training regarding new job duties, including policies and procedures from DMH, DHS, and COA addressing foster care and licensing standards. Recruitment for foster parents has begun, and a class will begin in the next few weeks. Writing of the Host Home policy and procedure manual has also begun and will encompass crisis and therapeutic foster care standards as well Host Home standards from other states.

Significance: Provision of partial funding for support of the new Host Homes Program facilitates outreach and identification of youth in need of comprehensive services because of their homelessness, including youth with serious emotional disturbances.

Funding: Federal

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

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

Criterion: Targeted Services to Homeless and Rural Populations

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

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

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

PI Data Table C4.2	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Children in Domestic Violence Situation	7*	8	74	75	100

Served					
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*Gulf Coast Women's Center was significantly impacted by Hurricane Katrina and its operations disrupted, but initial targets for FY 2005 were met since the storm occurred toward the end of the period. Targets for subsequent years were more conservative, considering the recovery period.

Source(s) of

Information: Grant proposal for existing program.

Special

Issues: This children's program is required to submit monthly data on the number of children served (targeted above) including the number of children with serious emotional disturbance.

Significance: This Gulf Coast Women's Center for Nonviolence provides shelter for children and their mothers who are experiencing violence at home. This center operated a 24-hour crisis line, provides housing and supportive residential services, court advocacy, community education, intensive counseling for children with serious emotional disturbance and a therapeutic preschool program.

Funding: Federal

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

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Crisis intervention services for youth in a shelter program

Indicator: Continued funding to support a CMHC in providing crisis intervention services, a therapist and other needed supports to a local shelter for abused/neglected children.

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

PI Data Table C4.3	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Abused/ Neglected Children Served	226 children served through Region 13 CMHC	298*	353	100	100

Source(s) of

Information: Grant proposal for the targeted CMHC

Special

Issues: None

Significance: Through this program, a CMHC therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the shelter. Staff of the shelter are also provided training by the CMHC in crisis intervention techniques, behavior modification, communication issues, children's reaction to abuse and neglect, and recognizing indicators of sexual abuse. The shelter serves children who have allegedly experienced abuse and/or neglect.

Funding: Federal

Therapeutic Group Homes and Therapeutic Foster Care Services

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

Coordination with Other Agencies

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). These programs most likely will include emergency shelters approved by the Department of Human Services and/or other appropriate state agencies.

Goal: Facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels) in development of a system of care for children with serious emotional disturbance.

Objective: To provide technical assistance to programs in the state serving children/youth with serious emotional disturbance

Population: Children with serious emotional disturbance

Criterion: Targeted Services to homeless/runaway youth

Brief Name: Educational opportunities for staff

Indicator: Provision of information on applicable training/education opportunities made available through the DMH Division of Children and Youth Services to programs

serving children/youth with serious emotional disturbance.

Measure: Number of technical assistance activities and/or training offered by DMH staff.

Source(s) of Information: Children and Youth Monthly Staffing Forms

Special Issues: None

Significance: Homeless/runaway youth, including youth with serious emotional disturbance, are more likely to be in emergency shelters approved by the Department of Human Services and/or other appropriate state agencies; therefore, these shelters will be targeted for inclusion in applicable children's mental health training activities.

Funding: State and local funds, CMHS, federal discretionary, and other grant funds

Definition of areas of the state considered "rural"

In its continued efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas, the Department of Mental Health will use the new definition of "rural," based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:

"Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)" are classified as "rural." More specifically, the Census Bureau "delineates UA and UC boundaries to encompass densely settled territory, which consists of:

- Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
- Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are "split" between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural."

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

Regionalization of Services: Availability and accessibility of services for children with serious emotional disturbance and their families in rural areas are addressed through some of the same structural and programmatic characteristics of the public community mental health system, as described under Criterion 4 in the Adult Plan. These include regionalization of community mental health services, county mental health offices and school-based services. Expansion of children's mental health services within the existing regional system, so that components of the

system of care are available statewide, is the ultimate goal of planning and service development efforts reflected in the State Plan.

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

Emphasis on School-Based Services: 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. For the past few years, individual, group and family therapy have become available through an increasing number of school districts through school-based CMHC therapists. Availability of school-based day treatment programs has continued to increase in recent years. Case managers facilitate significant outreach efforts in rural communities across the state by building communication between school and home and across other community services. (See objectives on school-based outpatient and day treatment services and on case management services, under Criterion 1.)

Since much of Mississippi remains rural, 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. Linkages with schools, which have continued to expand over the last several years, have been received positively by both families and school staff across the state. School district personnel have demonstrated significant willingness to promote accessibility to mental health services at school sites. Technical assistance regarding strategies for expanding and gaining access to services will continue to be made available, upon request, by DMH Division of Children and Youth Services staff as each CMHC region is visited and through specific training sessions/workshops, and activities facilitated by the Division, i.e., case management training, crisis management training and financing strategies.

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

Goal: To further support the availability of, and access to children's mental health services across all counties in all 15 community mental health regions.

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

Population: Children with serious emotional disturbance

Criterion: Targeted Services to Rural and Homeless Populations

Brief Name: Technical assistance on service expansion

Indicator: Availability of technical assistance regarding the availability of and access to school-based services across CMHC regions.

Measure: Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools.

PI Data Table C4.4	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Providers Receiving T.A. /certification visits	15	15	10	10	15

Source(s) of Information: Monthly Division Activities Report

Special Issues: Technical assistance is typically provided upon request, which will make the number of CMHCs that receive such assistance vary across years.

Significance: The availability of mental health services in schools is a major strategy in reaching children with serious emotional disturbance and their families who live in rural areas, particularly those with limited or no transportation. Technical assistance/training opportunities offered to CMHCs on service expansion throughout the year are recorded monthly by DMH staff.

Funding: Federal, state, and local funds

Transportation Assistance is provided by some community mental health centers that have vehicles for transportation or through other child service agencies in some areas. For example, in FY 2008, 13 CMHCs and eight other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; 11 CMHCs and one other nonprofit program reported making transportation available through affiliation agreement with other agencies; and, five CMHCs and four other nonprofit programs reported utilizing local public transportation (buses, cabs, etc.).

The Telepsychiatry Project (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), with plans for expansion to some satellite sites in FY 2010. The project also is designed to provide training to front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing).

Criterion #5: Management Systems -

- **Describes financial resources, staffing and training for mental health service providers**

that are necessary for the implementation of the plan.

- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved(FY 2010)

Children's Community Mental Health Services

Financial Resources	Available in FY 2009	Projected, FY 2010
Federal Grants (CMHS, SSBG)	3,473,972	3,473,972
State Funds (grants, Medicaid match)	6,466,570	4,988,107
Healthcare funds (grants, Medicaid match)	1,757,843	1,757,843
Trf. from CMHCs for Medicaid match	6,229,023	7,380,000
Local Taxes*	3,324,957	3,324,957
Local Fees	2,250,000	2,250,000
Federal Medicaid Reimbursements*	52,361,422	54,458,935
Total	75,863,787	77,633,814

*Based on estimated use of funds for children's services of 45% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

Efforts to Increase Funding

Mississippi's budget process is such that fund the Department of Mental Health requests in the 2009 legislative session, which began in early January) and would ordinarily meet for 90 calendar days, would actually be available for the fiscal year beginning July 1, 2009 and ending June 30, 2010. But this year was an unusual year, with a couple of extensions to the regular session and 3 special sessions (the first of which occurred during one of the extensions of the regular session), and it was not until the 2nd special session that DMH received an appropriation. Even then, it was not until June 30 that the appropriation bill for the year that began the very next day was passed by both chambers of the legislature, and not until July 13, 2009, thirteen days after the fiscal year began, that the Governor released the signed appropriation bill.

In its initial budget request, the Department of Mental requested an increase of \$63,056,062 in general funds for the year that began July 1, 2009. This requested increase was for all services provided through DMH (mental health services for adults and children, services to persons with intellectual and developmental disabilities, services to persons with Alzheimer's disease and other dementia, and services to persons with substance abuse diagnoses; inpatient and outpatient). Included in that initial requested increase were: \$24,000,000 to cover all Medicaid match for services provided by the 15 CMHCs (adults and children's services); \$1,006,678 to replace an anticipated cut in federal SSBG services (which cut did not happen); \$622,395 for group homes to be operated by East Mississippi State Hospital Community Services; \$1,810,671 for group homes

to be operated by North Mississippi State Hospital Community Services; and, \$135,000 for additional operating costs at community-based crisis centers. The sum of these requested increases, all of which were for community mental health services, is \$27,574,744, representing 44% of the total requested increase from General funds.

The appropriations process for DMH was complicated by the American Recovery and Reinvestment Act (ARRA, also known as “the stimulus plan”). Uncertainty about the benefits of ARRA meant that the legislature postponed appropriation bills for several state agencies, including the Department of Mental Health. By the time the final appropriation bill for DMH was passed, late on June 30, 2009, state source funds for community mental health services (adults and children) were actually reduced, mostly reflecting the lower state share of Medicaid as a result of ARRA, but also reflecting a greater share of match being paid by the CMHCs.

Considering both adults and children, the total projected funding for FY 2010 (\$206,373,281) is \$3,933,393 greater than funding available for FY 2009 (\$202,439,888). That increase is further broken down as follows:

Reduced state source funds available for state share of Medicaid	\$(3,285,474)
Increased contribution from CMHC’s for state share of Medicaid	2,557,727
Increased federal share of Medicaid	4,661,140
Total	\$3,933,393

(55% of each figure is deemed to be for adult services, and 45% is deemed to be for services to children.)

Goal: To increase funds available for community services for children with serious emotional disturbance.

Objective: The DMH will seek additional state funds for community mental health services for children with serious emotional disturbance.

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems

Brief Name: Funding Increase Request

Indicator: The Department of Mental Health will seek additional funds in its FY 2011 budget request for community support services for children with serious emotional disturbances.

Measure: Inclusion of request for increased state funds to support community mental health services for children in the FY 2011 DMH Budget Request.

Source(s) of Information: DMH Budget Request, FY 2011

Special

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

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

Funding: State

Staffing**Human Resources, CMHCs: Available in FY 2009 and Needed in FY 2010**

POSITION	Total Staff	Full Time	Part Time
1. Psychiatrists	27	7	20
2. Other Physicians	9	5	4
3. Psychologists, Ph.D.	15	8	7
4. Staff with Master's Degree or Above in Field of Psychology	72	71	1
5. Other Psychologists	3	3	0
6. Social Worker (MSW, Other Master Degree or Above.	171	167	4
7. Other Social Workers	55	54	1
8. Registered Nurses (AA or Above)	36	39	4
9. Licensed Practical or Vocation Nurses	14	9	5
10. Other Mental Health Professionals (Bachelor Degree or Above)	487	472	15
11. Other Mental Health Workers (Less that Bachelor's Degree)	376	275	101
12. Physical Health Professionals	7	5	2
13. All Other Staff (clerical, maintenance, etc.)	247	196	51

14. Totals	1526	1311	215
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Mental Health Transformation Activities: Workforce Development

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

Local Infrastructure Development: In FY 2009, the DMH, Division of Children and Youth Services continued to seek opportunities to provide or arrange for technical assistance and training for CMHC and other providers receiving funds through the DMH. As of March 2009, Division of Children and Youth Services staff provided and/or facilitated the following training on for providers of mental health services for children/youth: “FASD 101,” screening, referrals and assessments; cultural competency and diversity; treatment plan and progress note development; managing aggressive youth in therapeutic group homes; “MAP Team 101” training; youth suicide prevention (ASIST & safeTALK); Mississippi Mental Health System for Children and Youth with SED; Stress Management for Crisis Intervention providers; A-Team and Adolescent Offender Programs Updates; Substance Abuse Prevention; and, AOP certification process.

Goal: To facilitate human resource development in addressing staffing/training needs of providers of mental health services to children with serious emotional disturbance and their families.

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

Population: Children with Serious Emotional Disturbance

Criterion: Comprehensive, Community-based mental health system.

Brief name: Availability of technical assistance to DMH-certified programs

Indicator: Continued availability of technical assistance by DMH Division of Children and Youth staff to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.

Measure: The number and type of technical assistance/support activities made available to CMHCs/other nonprofit service providers.

Sources of Information: Division of Children and Youth staffing report forms

Special Issues: None

Significance: Division of Children/Youth Services will continue to offer technical assistance in the planning, implementing and/or improving services and programs for children and their families. This includes those programs that are identified in the DMH

Minimum Standards as core or minimum services that must be available in all CMHC regions.

Funding: Federal, state and local funds

In FY 2009, the DMH Division of Children and Youth Services sponsored the *First Annual Gulf Coast Suicide Prevention Conference* (April 2009) and a cultural and linguistic workshop (April 2009 for all providers). In July 2009, DMH plans to continue as a primary sponsor the *21st Annual Lookin' to the Future* and the *Mississippi Permanency Partnership Network Conference*, conducted by Southern Christian Services. In September 2009, DMH will also continue to sponsor the annual Mississippi Alliance for School Health Conference, with a pre-conference focusing on youth suicide prevention.

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

Population: Children with Serious Emotional Disturbance

Criterion: Management Systems

Brief Name: Statewide Conferences and or trainings on the System of Care

Indicator: Provision of support to statewide conferences and/or trainings for children's mental health service providers addressing system of care issues for participants from local and state child/family service agencies and families of children/youth with SED.

Measure: The number of statewide conferences and/or trainings sponsored or co-sponsored by the Division of Children & Youth Services.

PI Data Table C5.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Attendance at Statewide Institute or DMH-sponsored conference	553	796	885		
# of statewide conferences and/or training sessions				Four	Four

sponsored or co-sponsored by DMH CYS					
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Source(s) of**Information:** Registration Forms for the Conferences; Final Conference Reports**Special****Issues:** None**Significance:** Training of service providers, both in the public community mental health system and across agencies that serve children and families, is a vital factor in facilitating both quality services, as well as interagency collaboration.**Funding:** CMHS funds

Technical assistance to residential treatment providers and state inpatient psychiatric hospitals also will continue to be provided or facilitated by DMH Division of Children and Youth Services staff, as requested/needed. Staff from the psychiatric units at the state hospitals will also continue to be invited to participate in monthly MAP team coordinators' meetings, at which additional technical assistance is available.

Training of Emergency Health Workers in the Area of Children's Mental Health**Mental Health Transformation: Workforce Development in Provision of Evidence-Based Practices (NFC Goals 5.3 and 5.4)****Mississippi Trauma Recovery for Youth (TRY) Project**

A grant for the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), began in October, 2003. The Director of the DMH Division of Children and Youth Services served in an advisory role to the project. 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. As mentioned, TRY of Catholic Charities in Jackson, MS, is a member of the National Child Traumatic Stress Network (NCTSN), which works to develop and disseminate effective evidence-based treatments for child trauma; collect data for systematic study; and, help to educate professionals and the public about the effects of trauma on children. The goal of the NCTSN is to improve the quality, effectiveness, provision and availability of

therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward NCTSN's overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey –School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Mississippi has allocated part of its increase to the FY 2007 CMHS Block (\$52,511) to expand training in the evidence-based practice of trauma-focused cognitive behavioral therapy, building on "lessons learned" through the four-year Mississippi Trauma Recovery for Youth (TRY) project. The first Learning Collaborative effort provided training in the evidence-based practice of trauma-focused cognitive behavior therapy for a core group of mental health therapists and their supervisors at Gulf Coast Mental Health Center (Region 13 CMHC) from October 2006 through April 2007.

Funding from the FY 2008 CMHS Block Grant award will continue to be provided to Catholic Charities, Inc. to continue and expand the training to include additional clinical staff in community mental health programs. This national collaborative learning model has become a part of an approach for implementing an evidence-based practice at the community level in Mississippi, beginning with implementation of trauma-informed services for youth.

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. The project is designed so that clinical management information can be integrated into the overall quality management program at the direct service and administrative levels. As of March 2009, the Mississippi Trauma Recovery for Youth (TRY) Project had begun another Learning Collaborative for therapists in the south and central areas of the state; this Collaborative had been attended by 78 therapists and clinicians and by Learning Session II, had resulted in 121 children/youth receiving trauma-focused cognitive behavior therapy (TF-CBT). Each Collaborative involves supervisory staff in three, two-day Learning Sessions and in monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT.

Goal: To facilitate implementation of evidence-based practices for enhancing trauma-informed care.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Evidence-based practice training

Indicator: Provision of training for additional clinical staff in the evidence-based practice of trauma-focused cognitive behavior therapy through the learning collaborative model.

Measure: The number of additional community mental health services staff who complete training in trauma-focused cognitive behavioral therapy (65)

Mental Health Transformation PI Data Table	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Additional community mental health services staff trained in TF-CBT	Not an objective in the State Plan	130	83 Baseline	50	65

Implementation of the objective to provide training for CMHC staff in providing pre-evaluation screening for individuals being considered for civil commitment in the Adult Services Plan under Criterion #5 is applicable to CMHC staff providing pre-evaluation screening for adolescents being considered for civil commitment.

Initiatives Related to Children in Crisis in Schools

Additionally, as described under Criterion #1, Region 3 CMHC receives a specialized crisis intervention grant that helps support therapists in schools in that region. Also, Region 8 CMHC, through funding from DMH, provides therapeutic nurses in all four counties it serves and additionally, provides crisis case managers in Rankin County.

Other Initiatives for Training of Emergency Services Personnel

The DMH Division of Children and Youth Services will continue collaboration with the DMH Division of Community Services, which coordinates the Law Enforcement Task Force, to review the curricula used for law enforcement training for adequacy in addressing issues related to youth who might be encountered in a mental health crisis. Division staff will participate and/or support other efforts of the task force to assist or advise other agencies with responsibility for training emergency services personnel as requested. (The Department of Mental Health Minimum Standards for adults require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH.) Information on training offered by local providers regarding crisis management/intervention will continue to be reviewed.

Case Manager Training

Because of the vital role that case management plays in accessing and coordinating children's

mental health services, both within the mental health system and across agencies, the Division of Children and Youth Services plans to continue its efforts to provide and improve training for children’s mental health case managers, focusing on local infrastructure building. The training includes cultural diversity, case management philosophy and functions, developing individualized case management service plans and DMH minimum standards for children’s mental health case management. As of April 2009, four case management orientation sessions had been conducted in FY 2009, and 106 case managers were trained. Training and technical assistance for new case managers, as well as review sessions for existing case management staff, will continue to be available from DMH Division of Children and Youth staff, upon request from CMHCs. Technical assistance, orientation and support for case managers are also available at the local level through existing staff at the CMHCs. Additionally, as described in the following section on the certification/licensure program, the Department of Mental Health has also developed a certification program for case managers.

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

Brief Name: Case management training provided

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

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

PI Data Table C5.3	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Case Management Training Sessions	8	8	8	8	8

Source(s) of

Information: Division of Children and Youth Services staffing report forms

Special

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

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

Funding: Local, state, and federal funds

Mental Health Therapist Certification and Licensure Program

The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master's level or above mental health staff members who are employed within Mississippi's state mental health system and who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist curricula was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 contact hours of mental health-related training over a two-year period in order to meet biennial renewal requirements.

Mental Health Administrator Licensure Program

The Mental Health Administrators program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master's level or above individuals who hold positions as the top-level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Program Participants are required to successfully complete the Mississippi Certified Public Manager program and a series of written examinations based on Mississippi rules/regulations/standards. After these requirements have been met, Program Participants are issued licensure as Mental Health Administrators. Once licensed, each individual is expected to accrue at least 40 contact hours of continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor's level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of Provisional Certification and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, a number of changes were made:

- In an effort to make information and application materials more readily available and to control printing and mailing costs, PLACE staff began converting credentialing information booklets and application forms to a web-based format. Therefore, PLACE staff will no longer track how many application booklets are mailed out.
- In an effort to control travel costs for program participants and DMH staff, PLACE staff converted the previously required three Mental Health workshops and exams into one study guide and one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. In the future, the study guide will be available online.
- In an effort to control travel costs and promote flexibility for administrators, PLACE staff changed the training requirement for the Mental Health Administrator program from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- In an effort to control travel costs for program participants and DMH staff, PLACE staff changed the training requirement for the Case Management program from three workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.
- In an effort to reduce duplication of information and effort, the reporting of continuing education hours is no longer required when an individual applies to move up from provisional certification to either full certification or licensure. Reporting CE's is now only required upon renewal.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Mental Health Administrator Program and the Case Management Certification Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report contact hours of ongoing in-service/training when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of the number of individuals in the process of pursuing ongoing in-service/training.

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

Population: Children with Serious Emotional Disturbances

Criterion: Management Systems

Brief Name: Number of DMH-certified/credentialed staff

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

Measure: The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees in the Mental Health Administrator program; the number of individuals who hold a credential in the Case Management Certification program.

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

Special Issues: None

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

Funding: State funds

The number of individuals who hold a credential in the Mental Health Therapist program, the number of Program Participants in the Mental Health Administrator program, and, the number of individuals who hold a credential in the Case Manager Certification Program in FY 2006 –FY 2008 and projected for FY 2009 – FY 2010 are indicated in the chart that follows:

Credentialing Program	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Mental Health Therapists (all levels)	1,495	1,733	1,959	1,973	2,175
Mental Health Administrators (all levels)	104	121	122	122	125
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	Program implemented on July 1, 2005	–	–	-	
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	76	367	629	607	845

Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in FY-2008, with 14 CMHCs and eight nonprofit programs reporting various training linkages pertaining to children's mental health with

state universities and/or state community colleges, as well as private colleges. Areas of training/disciplines represented included: nursing, psychology, social work, psychiatry, (including child psychiatry), sociology, art therapy, social science, community counseling, education, school counseling, rehabilitation counseling, family and human development, public policy and administration, family studies, marriage and family therapy, public health, industrial counseling, educational psychology, criminal justice and human services. Additionally, the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) has integrated the child psychiatry fellowship program at UMMC with Mississippi State Hospital's Oak Circle Center staff and facilities.

Telepsychiatry Project

The UMMC Department of Psychiatry received a grant from the Delta Health Alliance and began implementing a telepsychiatry service with two sites in the Delta region in FY 2009. They initiated services in early August 2008 for two community mental health centers (in Greenwood and in Clarksdale). In addition, the telepsychiatry service will link with the telepsychiatry unit based at MS State Hospital to provide continuity of care for those individuals admitted to the MS State Hospital from the designated Delta community mental health centers. The Department of Psychiatry will also use the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). The telepsychiatry project will receive additional funding from the Delta Health Alliance during the next fiscal year (FY 2010) to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. In addition, the Department of Psychiatry is looking into ways of sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

Information Management Systems Development

The Department of Mental Health will continue ongoing efforts to implement a more standardized system of computerized data collection, including data needed for reporting on the National Outcome Measures (NOMS) and data needed for reporting in the Uniform Reporting System tables requested by the federal Center for Mental Health Services (CMHS). The national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the DMH has applied for and received three, Mental Health Data Infrastructure Grants (MH-DIG) from the CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.

As mentioned, the DMH has used the DIG funds to support design, refinement and implementation of reporting systems that will facilitate community service providers' and state psychiatric hospitals' submission of data contained in the URS tables. DMH submitted the following URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16(some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, the DMH has continued to use DIG funds to support collection and reporting of consumer satisfaction survey information for adults and families of youth served by the public community mental health system. Consumer satisfaction survey information is also being collected to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2010, efforts will continue to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan-related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers' local systems have been problematic in state-level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH - DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined information that is detailed to the client level from all DMH certified and funded providers. As a result, the DMH now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children's services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser based system for data entry from these organizations.

The DMH Division of Information Systems and Division of Planning staff will continue to participate in CMHS conference calls and national meetings, held regularly to discuss the development of the URS data tables. DMH staff also will communicate regularly with the the community mental health centers'/other providers' data managers as progress on development of the URS data tables continues. DMH Division of Information Systems and Division of Planning staff will also continue work with programmatic staff at the state level in the Bureau of Mental Health and at the local provider level to coordinate development of state plan reporting, including

National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the *Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2008-FY 2010)*, which will enable the Mississippi Department of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts for the Uniform Reporting System measures, including the National Outcome Measures as required for the CMHS Block Grant program, to identify trends in services and outcomes, and increase the involvement of stakeholders in planning. The goals of the proposed project are to: (1) Refine the central data repository for public mental health system data; (2) Refine the process for collection and reporting of information from consumer and family satisfaction surveys; (3) Improve data quality assurance systems; and (4) Increase accessibility and use of URS/NOMs measures and other mental health system data by the Mississippi State Mental Health Planning Council, DMH staff and other stakeholders involved in planning and system improvement activities. Through continued data infrastructure development, quality assurance and technical assistance activities described in this proposal, the integrity and completeness of timely, detailed data to support measures for the Uniform Reporting System (URS) tables, including the National Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well as integration of the measures with other quality assurance information, will facilitate state planning and performance improvements across the system of services and supports for individuals with mental illness and their families.

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

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

Population: Children with Serious Emotional Disturbance

Criterion: Management Systems

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

Indicators/Strategies:

- A) Work will continue to coordinate the further development and maintenance of uniform data reporting and further development and maintenance of uniform data standards across service providers. Projected activities may include, but are not limited to:
- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the CMHS Data Infrastructure Grants, including the FY 2008-2010 MH DIG Quality Improvement project;
 - Periodic review and Revision of the DMH Manual of Uniform Data Standards;
 - Continued communication with and/or provision of technical support needed by DMH Central Office programmatic staff who are developing performance/outcome measures;

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

- Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs:
- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the FY 2008-2010 MH DIG Quality Improvement project;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Measure: Progress on tasks specified in the Indicator.

Special

Issues: As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

Significance: Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

Funding: State funds, Federal funds

**Projected Expenditures of Center for Mental Health Services Block Grant
Funds for Children's Community Mental Health Services
by Type of Service for FY 2010**

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

**Projected Allocation of FY 2010 CMHS Block Grant Funds
For Children's Services by Region/Provider**

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

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

Singing River Services 101-A Industrial Park Road Lucedale, MS 39452 Sherman Blackwell, II, Executive Director (MAP Team flexible funding)	15,357
Warren-Yazoo Mental Health Services P. O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director (Intensive Case Management and MAP Team flexible funding)	70,357
Catholic Charities, Inc. 200 N. Congress St., Suite 100 Jackson, MS 39201 Greg Patin, Executive Director (Family Crisis Intervention, TFC, and Comprehensive Emergency/Crisis Response & Aftercare Model, TFC, TF-CBT training and MAP Team flexible funding)	365,398
Gulf Coast Women's Center P. O. Box 333 Biloxi, MS 39533 Sandra Morrison, Director (Intensive Crisis Intervention)	30,000
Mississippi Children's Home Society and CARES Center P.O. Box 1078 Jackson, MS 39215-1078 Christopher Cherney, CEO (Therapeutic Group Home)	125,722
MS Families As Allies for Children's Mental Health, Inc. 5166 Keele St., Bldg. A Jackson, MS 39206 Tessie Schweitzer, Executive Director (Crisis Intervention/Respite, flexible funding for services for youth by the State-level Interagency Case Review Team, other System of Care (SOC) development activities (ex.: more flexible funds, as needed; SOC training; ICCCY planning/activities)	221,040
Southern Christian Services for Children and Youth 1900 North West St., Suite B Jackson, MS 39202 Sue Cherney, Executive Director (Mental Health Services for Transitional TGHs and Training)	120,000

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

Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar St.
Jackson, MS 39201
Edwin C. LeGrand III, Executive Director
(Funds to support peer monitoring, and
and training, which may be granted to local
entities for implementation) 17,424
5,000

TOTAL \$1,549,296

Note: A total of \$187,179 (5% of the total amended award to be spent on services in FY 2010) will be used by the Mississippi Department of Mental Health for administration. It is projected that \$84,231 will be spent for administrative expenses related to children’s community mental health services.

Table C. Mental Health Block Grant Funding for Transformation Activities

Transformation Activity	Column 1	Column 2
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the actual or estimated amount MHBG funding that will be used to support this transformation goal in FY 2009
Goal 1: Americans understand that mental health is essential to overall health.		
Goal 2: Mental health care is consumer and family driven.	X	\$466,057
Goal 3: Disparities in mental health services are eliminated.	X	\$ 90,000
Goal 4: Early mental health screening, assessment, and referral to services are common practice.	X	\$417,696
Goal 5: Excellent mental health care is delivered and programs are evaluated.	X	\$160,022
Goal 6: technology is used to access mental health care and information.		

Goal II: Mental health care is consumer and family driven.

Programs and/or services supported with CMHS Block Grant funds that are family-driven include respite services (\$45,741), which are coordinated and provided through Mississippi Families As Allies for Children's Mental Health, Inc.; Making a Plan (MAP) Team activities (\$402,892), which involve family members in a state-level and local interagency teams that coordinate services and individualized planning for youth with serious emotional disturbances who have complex needs; and, peer review monitoring activities (\$17,424), which include family members with professionals in on-site program monitoring. (Note: Peer monitoring also addresses Goal V.)

Goal III: Disparities in mental health are eliminated. CMHS Block Grant funds (\$90,000) are used to support provision of therapeutic nursing services provided in school-based programs in two community mental health regions. Providing services through school-based sites is a major strategy in increasing access in rural areas. (Provision of therapeutic nursing services in school-based programs also addresses Goals I and IV.)

Goal IV: Early mental health screening, assessment and referral services are common. Crisis intervention programs (\$266,935) and one sexual abuse intervention programs (\$25,039) supported with CMHS Block Grant funds (some of which are also school-based) all emphasize early identification, assessment, referral and treatment. CMHS Block Grant funding (\$125,722) also supports the provision of community-based residential treatment services for youth with co-occurring disorders of serious emotional disturbance and substance use/abuse.

Goal V: Excellent mental health care is delivered and programs are evaluated. CMHS Block Grant funds are used to support implementation of evidence-based practices, including the provision of therapeutic foster care services (\$30,000) and training in trauma-focused cognitive behavior therapy (\$52,511). Other workforce development activities are supported through CMHS Block Grant funds (\$77,511), including a statewide annual conference for children's mental health service providers. Topics addressed at this conference also relate to other Transformation Goals (e.g., cultural competency training would also address Goal III).

Note: Activities that address **Goal I: Americans understand that mental health is essential to overall health**, such as a statewide anti-stigma campaign and a youth suicide prevention initiative, are supported with state and/or other federal funds.

b) FY 2010 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SERIOUS MENTAL ILLNESS

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

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

Organizational Structure and Development of the System of Care

As described previously, 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. As further discussed under Criterion #4 that follows, these centers operate regional or satellite offices/services in 81 of the 82 counties. The mental health centers are governed by regional commissions, with representative commissioners for each county in the region appointed by county Boards of Supervisors. As described in more detail in the Section I, the Mississippi Department of Mental Health sets and monitors implementation of minimum 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, management and in specific services, is monitored through on-site visits of programs throughout the year by DMH staff. Some community services (such as case management, psychosocial rehabilitation, group homes and supervised apartments and specialized programs for homeless persons who are mentally ill) are also provided to some individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These services are primarily for individuals discharged from the hospital and are in the areas in close proximity to the hospitals (Jackson and Meridian). These programs are also monitored for implementation of minimum 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 facilities and also provide crisis residential services in three areas of the state

Inpatient services are provided directly by the MS Department of Mental Health, which has regionalized acute psychiatric inpatient services and has operationalized a statewide system of regional crisis centers. (See Section I, Description of the State Service System.)

Federal and State Resources

The FY 2010 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2009 Session. Also included under Criterion #5 in the Children's Plan and in the Adult Plan are objectives to request additional state funds for the 2010 fiscal year. Changes indicated under this criterion also reflect a decrease to FY 2009 (current year) federal CMHS Block Grant funds. The Department of Mental Health (DMH) administers and grants to local providers funding from the federal Community Mental Health Services (CMHS) block grant and the Substance

Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as PATH funding for specialized programs for homeless persons). The DMH also applies to the MS Department of Human Services for a portion of Mississippi's federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently, administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. As mentioned, in recent years of budget restrictions, the community mental health centers have also made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers. In FY 2008, the Legislature made and the Governor approved a deficit appropriation of an additional \$10 million in state matching funds for community mental health centers.

The legislation that provides for the establishment, structure and operation of the regional commissions for mental health/mental retardation also authorizes participating counties to levy up to two mills tax for programs designed by the regional commission. The DMH also performs fiscal audits of programs receiving funding through its Bureau of Administration.

Sources listed under the heading of "Funding" within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under "Funding" does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited to those providers who receive specific program grants (including CMHS grants) and may be limited to those adults or children served through the grant.

Ideal System Model

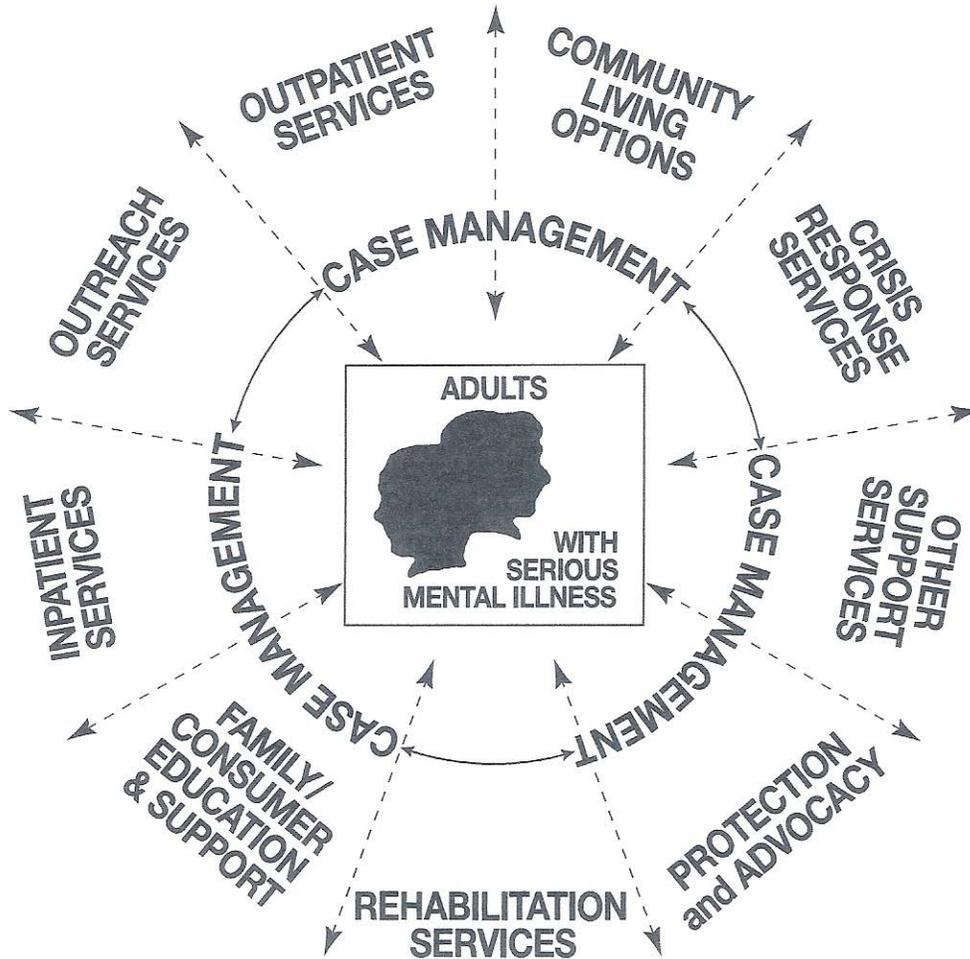
The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness (next page) was developed to reflect an ideal system that is responsive to the strengths and needs of all individuals with serious mental illness. At the center of the system is the person, each with his or her individual strengths and needs, which vary across time and circumstances. Revolving around the person and between the person and his or her family and components of the mental health and support system, is case management. Case management is the key to accessing and coordinating mental health and support services needed by the individual at any given time. In the ideal system, the case manager continually works with the individual to aid in identifying that person's goals, helping them to recognize strengths and barriers, and in developing and implementing an action plan based on identified needs. The Ideal System Model for Adults emphasizes a psychosocial rehabilitation approach to making an array of appropriate mental health, social, vocational, educational, and other support options available, based on individuals' strengths, as well as their needs. Several types of service options and activities may be included in the service components of the Ideal System Model. 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 person-directed and thus, individualized. In 2006, the Mississippi State Mental Health Planning and Advisory Council decided to work through its committee structure as appropriate to develop additional strategies for enhancing the effectiveness of and sensitivity to consumer and family input at the local service provider level. The major service components of the Ideal System Model for Adults include: case management, outpatient services, crisis response services, alternative living arrangements (housing), identification and outreach, psychosocial rehabilitation services, family/consumer education and support, inpatient services, protection and advocacy, and other

Mississippi

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. (Services for persons with co-occurring disorders are described in detail in a separate section that follows under this Criterion.)

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 Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- Emphasis on Recovery

Systems Development Initiatives

Other Cooperative Initiatives with the Division of Medicaid

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 Center 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.

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

Mental Health Transformation Activity: Individualized Treatment/Service Planning (NFC Goal 2.1)

Person-centered Planning

The Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services will continue to require that providers conduct an Initial Intake Assessment for all individuals in the caseload with a serious mental illness. The assessment is conducted with every individual who has a serious mental illness within 30 days of admission for outpatient services and within seven days of admission for all residential treatment services. During the annual site/certification visits, it is determined whether or not the assessments are completed.

In FY 2002, the MS Department of Mental Health, in collaboration with the Division of Medicaid, Office of the Governor, was funded by the federal Centers for Medicare and Medicaid Services (CMS) for a Real Choice Systems Change grant project, designed to shift philosophy and practice to a more person-directed planning and support service delivery approach, and to demonstrate effectiveness for individuals being discharged from or at high risk of entering a state hospital or intensive residential treatment programs in four community mental health regions (Region 6, 13 and 15, and later 12). DMH received a no-cost extension of the PCP project in 2006, during which training in the person-centered planning model was disseminated to other community mental health regions.

Among the lessons learned through this project was that traditional case management services need to be driven by the person receiving services and that much more workforce training regarding exactly how to provide supports for individuals in their recovery process was needed. Since the conclusion of the grant project, new strategies for providing case management, as well as individual and family therapy, are being incorporated in meetings with the Case Management Task Force and Case Management Orientation. Person-centered planning has continued in Regions 12 and 15, which were involved in the pilot program, and staff from those regions are available to provide training statewide on person-centered planning. Person-directed lessons are also being addressed in training on treatment plan development that is provided by the DMH Division of Community Services. NAMI-MS, the Mississippi Leadership Academy, and the Mental Health Association are also mindful of the principle of person-directed services in the training they provide to individuals receiving services and their families.

The DMH Division of Community Services is hopeful that individuals receiving services, as well as direct service and administrative staff from the community mental health regions, will adopt the philosophy and approaches piloted in the PCP project and provide more person-directed, recovery-oriented services for people in the system of care. The Division of Community Services will continue to review existing service standards for potential revisions that would support sustaining of PCP initiatives in the future.

Quality Improvement System Development

As described in Section I, the MS Department of Mental Health continues efforts to address provision of the comprehensive Mental Health Reform Act, passed by the State Legislature in 1997. Consistent with the call for increased access, quality and accountability of services in the Mental Health Reform Act, the Mississippi Department of Mental Health continues work to improve its system of program evaluation and planning, a key focus of which is further development of its data infrastructure and information management systems, described in more detail under Criterion 5. As noted throughout the plan, these efforts also address improving performance and outcome measurement and reporting at the local and state levels, including increasing capacity to report on National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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

Peer Review

In addition to monitoring community mental health service providers' compliance with minimum standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in adult community mental health services, consumers, families and other stakeholders. As of April, 2009, peer reviewers for adult community mental health services visited eight community mental health centers and involved 16 different peer reviewers. Of the 16 reviewers, 10 were individuals receiving services, three were family member and three were mental health professionals. In FY 2008, the Department of Mental Health provided a peer review satisfaction survey to CMHC directors, State Hospital Directors, peer reviewers and interested stakeholders. DMH suspended the peer review process for a few months to evaluate survey results and make efforts to implement changes. Using feedback from the survey, the Division made some changes to improve the peer review process in FY 2009. The peer review visits now involve a smaller, more focused team of a consumer representative, a family member and another interested stakeholder, and a sample of each type of program is visited during the peer review. The Division developed a manual guide for peer reviewers that describes services available by region, including the core services and other specific services offered in each region; pictures of service locations were added to addresses when applicable. Also, a pre-conference visit is now held with service providers, in addition to the exit conference at the close of the visit.

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

Objective: To refine the peer review/quality assurance process for all adult community mental health programs and services based on survey responses from community mental health center directors, peer reviewers, and interested stakeholders (i.e., NAMI-MS, MHA).

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation of peer review

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

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

Source(s) of

Information: Peer review reports, which are mailed to the community mental health centers and the Division of Community Services at East MS State Hospital and MS State Hospital.

Special

Issues: Peer monitors include family members, consumers and/or professional staff. Typically, peer review teams conduct visits in conjunction with DMH standards monitoring visits. The number of peer review visits conducted within a given time period can vary, which is related to variations in the certification visit schedule

Significance: The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Peer review site visits provide additional technical assistance opportunities for community programs from other providers in the state on a regular basis.

Funding: CMHS Block Grant Funds

Consumer Satisfaction Survey

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

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

Target: Maintain percentage of adults with serious mental illness who respond positively about outcomes.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Indicator: Adults with serious mental illness responding to a satisfaction survey who respond positively about outcomes.

Measure: Percentage of adults who respond to the survey who respond positively about outcomes

Sources of Information: Results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH).

Special Issues: Administration of a state variation of the *MHSIP Consumer Satisfaction Survey* using a revised methodology to produce statewide results began in FY 2004. With consultation and approval from CMHS, the MHSIP was not administered in 2005 because of a delay in start-up (due to a change in staff working on the project) and state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. DMH has worked with the University of Mississippi Medical Center, Center for Health Informatics and Patient Safety, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* in FY 2006 - FY 2009 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

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

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

Satisfaction Survey of Individuals Receiving Services

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual*	FY 2007 Actual	FY 2008 (Actual)	FY 2009 Target	FY 2010 Target
Performance Indicator					
% Reporting Positively about Outcomes	87%	71%	71%	71%	77%
Numerator	459 positive responses	491 positive responses	447 positive responses	491 positive responses	476 positive responses
Denominator	528 responses	690 responses	628 responses	690 responses	615 responses

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

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

Satisfaction Survey of Individuals Receiving Services

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual*	FY 2007 Actual	FY 2008 (Actual)	FY 2009 Target	FY 2010 Target
Performance Indicator					
1. % Reporting Positively about Access	89%	87%	89%	87%	88%
Numerator	471 positive responses	593 positive responses	564 positive responses	593 positive responses	543 positive responses
Denominator	536 responses	679 responses	636 responses	679 responses	617 responses
2. % Reporting Positively about Quality and Appropriateness for Adults	89%	88%	90%	88%	89%
Numerator	478 positive responses	599 positive responses	569 positive responses	599 positive responses	549 positive responses
Denominator	535 responses	679 responses	635 responses	679 responses	616 responses
3. % Reporting Positively about Outcomes	87%	71%	71%	71%	77%
Numerator	459 positive responses	491 positive responses	447 positive responses	491 positive responses	476 positive responses
Denominator	528 responses	690 responses	628 responses	690 responses	615 responses
4. % Reporting on Participation in Treatment Planning	79%	74%	76%	74%	76%
Numerator	424 positive responses	480 positive responses	480 positive responses	480 positive responses	461 positive responses
Denominator	535 responses	657 responses	631 responses	657 responses	608 responses
5. % Reporting Positively about	88%	90%	90%	88%	89%

General Satisfaction with Services					
Numerator	471 positive responses	603 positive responses	574 positive responses	471 positive responses	549 positive responses
Denominator	534 responses	673 responses	637 responses	534 responses	615 responses

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

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

The Office of Constituency Services was established by the Department of Mental Health in response to a provision in the Mental Health Reform Act. The major responsibilities of this office include establishing and maintaining a 24 hour toll-free help line for responding to needs for information by consumers and their family members and other callers to the help line. This office is also responsible for responding and attempting to resolve consumer complaints about services operated and/or certified by the Department of Mental Health. Policies and procedures have been developed for resolving consumer complaints, both formally and informally. This office also maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. Information is accessible to all callers through staff via a toll-free telephone number. The number is accessible 24 hours a day, seven days a week. OCS is also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran. The DMH Minimum Standards for Community Mental Health/Mental Retardation Services address services provided by OCS, including: (1) accessing the help line for information, referrals and complaints; (2) reporting serious incidents to DMH; and, (3) the availability of local grievance procedures, as well as procedures for grievances through OCS.

OCS staff participates in certification visits to each program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. This Office also continues to process and attempt to resolve consumer complaints through formal and informal procedures and track calls to develop reports for DMH management staff. Reports about the nature and frequency of calls to the help line (deleting all confidential information) are distributed quarterly to the DMH Executive Director, Bureau Directors and the OCS Advisory Council. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS has developed training modules on serious incident reporting, handling crisis and suicide calls, and any applicable minimum standards monitored by OCS. These modules are available as requested by any DMH-certified program. In FY 2009, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities). Additionally, OCS continues to publish, distribute, and update the “Directory on Disk” program to all DMH facilities and community mental health centers, as well as

DMH Central Office staff. This directory gives service providers access to basic program/ service information for over 2000 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the statewide database (approximately 200 new or updated programs in FY 2009) used for information and referral; this process is also ongoing.

Objective: To maintain a toll-free consumer help line for receiving requests for information, referrals and for investigating and resolving consumer complaints and grievances and to track and report the nature and frequency of these calls.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Constituency Services Call Reports

Indicator: Continued tracking of the nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software.

Measure: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports).

Source(s) of

Information: Data provided through the software, as calls to the OCS help line logged into the computer system.

Special

Issues: Dissemination of the directory on disk (a read only version containing program information) is being provided only to DMH-certified and funded providers who sign a use agreement to ensure preservation of accurate and current data.

Significance: The establishment of a toll-free grievance telephone reporting system for the receipt (and referral for investigation) of all complaints by clients of state and community mental health/retardation facilities is a provision of the Mental Health Reform Act of 1997. The concurrent development of a computerized current database to also provide callers with information and assistance facilitates access to services by individuals expands the availability of current and detailed statewide service information to community mental health centers.

Funding: State General Funds

Mental Health Services

Local Community Support Systems Planning

In 1993, a task force on community support developed requirements for each service of the ideal system

of care that could be used as an outline for service providers to use to plan their local plans, referred to at that time as Community Support Programs (CSP). Since then, this outline, which has been modified somewhat over time, has been used for the program narrative outline required when service providers apply for CMHS block grant funds. These grants make available a portion of the CMHS Block Grant to community mental health centers to be used on a purchase-of-service basis for various services within the system of care, such as medication evaluation and monitoring, individual therapy, family therapy, group therapy, administration of injectable psychotropic medication, case management, psychosocial rehabilitation and emergency services. (Projected use of CMHS Block Grant funds for specific services is described in more detail under Criterion 5.)

Regional community mental health centers are required in their plans to describe how these services and other community support services for adults with serious mental illness will be provided at the local level, addressing the following components: outpatient services; family and consumer support; access to inpatient services; availability of alternative living arrangement services; protection and advocacy; programs for psychosocial and vocational rehabilitation; crisis response system; case management; outreach; and, access to medical/dental services and to other support services, such as transportation and social activities.

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

Multicultural Task Force

Mississippi has a significant minority population. According to 2000 U. S. Census figures, Mississippi has a population of 2,844,658, with an estimated 39% of its citizens identified as nonwhite. Of the total number of nonwhite individuals, approximately 94% are African-American. Additionally, as a largely rural state, there is a great need for cross-cultural awareness and sensitivity in outreach and mental health service delivery activities

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the 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. The task force membership has been expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling has also been helpful. There are currently 36 members on the task force, including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-Mississippi; Mental Health Association Director; Jackson State University, School of Social Work; Jackson State University, SMHART (Southern Institute for Mental Health Advocacy, Research and Training); Jackson-Hinds Community Health Center, Ellisville State School, Jackson Healthcare Center, Grant Consultant; and Chairperson of the Mississippi State Mental Health Planning and Advisory Council. The Multicultural Task Force Strategic Map mission statement 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.” The definition of cultural competency chosen by the task force members is: “the acceptance, understanding and embracing of all cultures.” “Culture” refers to an integrated pattern of human behaviors that includes language, thoughts, communications, actions, customs, beliefs, values and institutions of all individuals. As of March 2009, the Multicultural Task Force had organized the annual statewide Day of Diversity (October 13, 2008) and held a meeting on November 21, 2008. The Co-Chairperson of the Multicultural Task Force presented on cultural competency and disparities at the 27th Annual MH/MR Joint Conference. On April 17, 2009, a workshop (*Cultural and Linguistic Competency: Keeping It Real*), featuring Dr. Vivian Jackson with the National Center for Cultural Competency was held in Jackson, MS, and attended by 85 service providers. The task force has developed the *Draft, Mississippi Department of Mental Health Proposed Plan for Cultural Competency*, and a subcommittee met to develop the Communication Continuum for Sharing the Cultural Competency State Plan.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Multicultural Task Force operation

Indicator: Continued meetings/activity by the Multicultural Task Force

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

Source(s) of

Information: Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) made.

Special

Issues: None

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

Funding: State funds

Local Provider Cultural Competence Assessment

In FY 2001, the Multicultural Task Force initiated planning for use of a cultural competence assessment

instrument at the local level, with introductory information being provided to CMHCs regarding the potential piloting of such an assessment. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. Since 2002, a cultural competence assessment recommended by the task force has been implemented by community mental health regions 1, 3, 4, 6,7, 8, 11,14 and 15. Following these assessments, DMH staff has continued to offer and/or provide follow-up consultation to local providers in developing recommendations for action steps based on assessment results. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff have continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results. As of May 2009, Region 11 had received their cultural competency local assessment results and technical assistance (on May 8, 2009). The Co-Chair of the Multicultural Task Force had also scheduled a meeting to discuss the assessment with Region 2 CMHC.

Objective: To expand the cultural competency assessment pilot project to include selected regions in the northern part of the state and additional areas in the central region.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Cultural competency pilot project expansion

Indicator: To make available the opportunity for additional community mental health centers/providers to participate in the local cultural competency assessment project.

Measure: The number of community mental health centers/providers that participate in the local cultural competency assessment project.

Source(s) of

Information: Division of Community Services Activity Report

Special

Issues: Participation in the project will be voluntary.

Significance: Results from the administration of the cultural competence assessment will be available to be used by the CMHC/provider to determine areas of cultural competence that might need to be addressed.

Funding: State and local funds

In FY 2009, the Department of Mental Health continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model. NCBI training sessions were conducted in Region 3, Region 8 (Copolah County, Rankin County and Simpson County) in April 2009.

Goal: To provide appropriate, culturally sensitive services for minority populations.

Objective: To make training available to community services staff in cultural awareness and sensitivity.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Cultural diversity training availability, state level

Indicator: Availability of NCBI training sessions on cultural awareness and sensitivity.

Measure: The number of NCBI training sessions made available to community mental health services staff. (Minimum of 3)

PI Data Table A1.4	FY 2006 (Actual)	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# of NCBI Training Sessions for CMHC Staff	6	5	4	4	3

Source(s) of

Information: NCBI: MS Chapter Training Records

Special

Issues: The Multicultural Task Force will continue to explore ways to assess the impact of the NCBI training, including participants’ next steps in encouraging or promoting diversity in the community. The number of training sessions provided depends on the number of requests for training received and availability of staff qualified to provide the training.

Significance: The State Plan calls for the operation of a Multicultural Task Force to address issues relevant to providing mental health services to minority populations in Mississippi, which has focused much of its efforts on training needs. Training has been provided to increase the cultural awareness and sensitivity of community services staff.

Funding: State and/or federal funds

Outpatient Services, a component of the ideal system, include diagnostic and treatment services in various treatment modalities for those persons requiring less intensive care than provided by inpatient services, including individuals with serious mental illness. Outpatient services include: individual, group, family, and multi-family group therapy and aftercare services, which are currently provided by all 15 CMHCs; medication evaluation and monitoring; emergency services and inpatient referral, part of the crisis response component of the ideal system, provided through the 15 regional CMHCs; family education/support and consumer education/support services, described under this criterion; case management services, available to adults with serious mental illness through the 15 CMHCs and the Community Services Divisions of East MS State Hospital and MS State Hospital; pre-evaluation screening and civil commitment services, including screening and examinations as needed; and psychosocial rehabilitative services, which include clubhouse programs.

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

Rehabilitation, Employment and Educational Services

Psychosocial Rehabilitative Services refer to a philosophical and programmatic approach to services for individuals with long-term serious psychiatric disabilities, making it not only a service component, but a pervasive characteristic of the ideal community system. The overall goals of psychosocial rehabilitation are to improve the quality of life of individuals with serious mental illness and to enable them to function as independently as possible. Essential to the psychosocial rehabilitation model are the identification of individuals' strengths and the mapping of goals to build on skills, not just to decrease symptoms of the mental illness. This process of building on existing skills and learning new ones is designed to improve or maximize functioning in life skill areas such as work, social life and educational areas. Within the range of psychosocial rehabilitative services, therefore, can be a variety of service options, including vocational training and job placement, training in skills of daily living and community living, case management, social, recreational and educational services, and other services that may generate and sustain natural supports. Services are provided for brief or indefinite periods, depending on the intensity of the person's problem. The major aim is to provide a comprehensive array of services to meet the range of potential needs and to maximize the strengths of the consumer at any given point in time.

Psychosocial rehabilitative services are therapeutic activity programs provided in the context of a therapeutic milieu in which consumers can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial rehabilitative services, which involve a continuum of services based on the level of need of the consumer, include psychosocial rehabilitation (clubhouse), day support, and acute partial hospitalization services, as well as psychosocial rehabilitation specialized for elderly persons.

Psychosocial Rehabilitation is a community support service for individuals with serious mental illness, which consists of a network of services that help them develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse refers to a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental support.

All CMHCs in the state provide psychosocial rehabilitation programs based on the clubhouse model. Principles of the clubhouse programs are:

- 1) to provide programs that enhance individuals' skill development;
 - 2) to improve employment opportunities for persons with psychiatric disabilities;
 - 3) to improve the capabilities and competence of persons with psychiatric disabilities...potential is emphasized over alleviating symptoms;
 - 4) to provide individuals the opportunity for active participation in their rehabilitation within an atmosphere in which things are done with the consumer and not to them;
 - 5) to promote positive expectations and respect for individuals, which are the essential ingredients of the program.
-

Availability of Psychosocial Rehabilitation Programs

As of April 2009, there were 16 psychosocial rehabilitation/clubhouse programs in the state, one in each of the 15 community mental health center regions and one operated by the MS State Hospital Community Services Division (in Jackson), with 60 clubhouse sites operational statewide.

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of clubhouse psychosocial rehabilitation programs

Indicator: Availability of clubhouse programs statewide.

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

PI Data Table A1.7	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 Target	FY 2010 Target
Availability of Psychosocial Rehabilitation Programs	16 Programs; 59 sites statewide served 4428 individuals	16 Programs; 61 sites statewide served 4574 individuals	16 Programs; 60 sites statewide served 4822 individuals	16 Programs	16 Programs

Source(s) of

Information: Adult Services Annual State Plan Survey

Special

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

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

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

Drop-In Center

In FY 2008 and FY 2009, the Mississippi Department of Mental Health continued to provide funding support to drop-in centers in Gulfport and in Corinth.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Drop-in center

Indicator: Availability of funding through DMH to help support two drop-in centers.

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

Source(s) of

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

Special

Issue(s): The drop-in center in Corinth has been relocated and expects to be able to provide transportation to program participants in the near future.

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

Funding: Federal and state.

Additionally, the day program for individuals at CMRC is based on a psychosocial model and focuses on transitioning individuals to a more independent setting in the community.

Improvements to the Psychosocial Rehabilitation Program

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

Clubhouse Coalition

A Clubhouse Task Force functioned in FY 2000-2001 to evaluate and recommend appropriate changes within the current clubhouse model. Major activities of the task force to date have included the coordination of individuals from clubhouse programs across the state participating in a three-week training program at the Internationally Certified Clubhouse Development (ICCD) training site, Gateway House, in Greenville, South Carolina; development of a training manual and provision of training for clubhouse staff and members regarding unit activities and transitional employment programs; and work on performance outcome measures for clubhouse programs. Based on recommendations of representatives of Gateway House and ICCD training sites made in FY 2002, the Clubhouse Task Force

became the Clubhouse Coalition after their July, 2002 meeting.

A primary objective of a Clubhouse Coalition is to form alliances and to collaborate with other organizations and state agencies that work to improve services for individuals with mental illness (such as the Department of Rehabilitation Services, the National Alliance on Mental Illness and the Mental Health Association. The coalition will also include clubhouse coordinators from the 15 mental health regions.

There are three ICCD-certified clubhouses in Mississippi: in Region 5 (Greenville), in Region 6 (Greenwood) and in Region 12 (Hattiesburg). Region 5 has been officially defined by ICCD as a Welcome Center. The ICCD-certified clubhouse in Greenville (Region 5) continues to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Clubhouse Coalition operation

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

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

Source(s) of

Information: DMH Clubhouse Coalition Minutes

Special

Issues: None

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

Funding: State funds

Training in the Clubhouse Model

Currently, three clubhouses programs have received International Center for Clubhouse Development (ICCD) Certification. Certification by ICCD is a credential which affirms that a program is operating a clubhouse in substantial compliance with the International Standards for Clubhouse Programs (in Regions 5, 6 and 12). Region 5 has been officially defined by ICCD as a Welcome Center. The ICCD-certified clubhouse in Greenville (Region 5) continues to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi. Since FY 2002, the DMH has continued to encourage and help support training for clubhouse programs, including training out-of-state at ICCD training sites and by technical assistance provided at in-state conferences and at local clubhouse sites. This training has included technical assistance focusing on the development of transitional employment opportunities. In FY 2009, two DMH staff members received training in Greenville, SC. (October 2008).

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Psychosocial rehabilitative services – training support

Indicator: Availability of funds through DMH to partially support training provided at ICCD-certified site(s) located in-state and/or out-of-state for staff in targeted clubhouse program sites. The remainder of the funds not used for this training will be used to support: (4) provision of technical assistance in-state by representatives of ICCD training sites (such as Fountain House in New York, NY, Gateway House in Greenville, SC or other training sites located out-of-state or in-state, such as the clubhouse programs in Greenville, MS or Greenwood, MS).

Measure: The number of clubhouse program sites that send staff to ICCD-certified sites for training and/or to which in-state technical assistance is made available

Source(s) of

Information: Program grants

Special

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

Significance: The need to increase training in the clubhouse model has been identified by the Clubhouse Task Force and by program monitors on certification/peer review visits. CMHS funds have continued to be used to assist in funding the cost to local programs of

sending additional staff to ICCD sites for out-of-state training, as well as in funding the cost of out-of-state ICCD site representatives providing training in-state. CMHS funds will also be used to assist in supporting training/technical assistance for clubhouse programs at sites located in Mississippi (Greenville and/or Greenwood).

Funding: CMHS Block Grant

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

Transitional Employment Program for Individuals With Serious Mental Illness

Part of the training to be made available to clubhouse members described in the previous objective will continue to be targeted to improving implementation of the transitional employment program component of the clubhouse rehabilitation program. The DMH anticipates that technical assistance on the transitional employment component of the psychosocial rehabilitation/clubhouse program will continue to be available, upon request, through the peer review teams and through other on-site consultants, depending on factors such as availability of the consultants and scheduling issues.

In FY 2009, the DMH continued to make available training/technical assistance targeted at improving implementation of the transitional employment component of the clubhouse rehabilitation program, which is recommended as needed by DMH staff. . Additionally, DMH made available funding to the two ICCD-certified clubhouses (in Region 5, Greenville and in Region 6, Greenwood) to support the development of training focused on transitional employment, which is part of the one-week clubhouse training Washington Square provides. Staff and clubhouse members from Washington Square continue to work with an ICCD representative to strengthen the transitional employment component of the training. The number of programs traveling to training sites has declined in the past year, primarily due to budget constraints.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Psychosocial rehabilitation program - training support

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

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

Source(s) of

Information: Program grants and DMH documentation of training.

Special

Issues: Of the individuals who attend special training for clubhouse staff at the model training program, those who have previously completed the basic parts of the training can opt to also attend a one-week training component on transitional employment. Also, technical assistance on transitional employment will continue to be made available to targeted regions by consultants and/or through in-state programs/peer review. The number of staff involved in these training/technical assistance initiatives will vary, depending on which regions participate and on availability of the consultants and scheduling issues. As mentioned previously, technical assistance on implementing the psychosocial rehabilitation/clubhouse program, including the transitional employment program component, is also available through the peer review process.

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

Funding: CMHS Block Grant

Other Efforts to Facilitate Transitional Employment Initiatives

To assist clubhouse programs in obtaining transitional employment positions, the Mississippi Department of Finance and Administration has continued to work with transitional employment programs, with several positions for individuals in various state agency buildings.

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

As in previous years, the DMH will continue to collect/report information on the number of individuals served in transitional employment programs, as defined by the state. DMH has continued work in FY 2009 to develop capacity to collect data for evidence-based practices by the FY 2010 timeline. The federal definition of “supported employment” as an evidenced based practice as proposed in URS Developmental Table 16 has some components that are similar to the state definition of supported employment, but differs along some components. DMH will continue activities through its Data Infrastructure Grant (DIG) project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported employment. DMH is continuing work on development of capacity for collection of data for the National Outcome Measures on evidence-based practices with support from the CMHS Data Infrastructure (DIG) Quality Improvement grant.

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

Goal: Facilitate the employment of individuals with serious mental illness served by the public

community mental health system.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

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

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

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

Special Issues: Finding jobs is a challenge in many parts of the state, especially in the current economic environment. (The moving 12-month average unemployment rate for the state as of March 2009 was 7.7%, and the average unemployment rate for March 2009 was 9.4%.) DMH continued work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 4. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and efforts to increase data integrity may result in adjustments to data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years. DMH plans to pursue collection of data in the Optional table 4A to gain additional information on employment status for individuals with mental illness, as potentially associated with diagnosis.

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

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

Coalition activities and efforts to address the need for more housing options described in the State Plan, will also be continued.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
Individuals employed as a percent of those served in the community	17.7%	17.9%	17.5%	17%	17.7%
Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)	9099	9219	9541	8670	9286
Denominator: # of persons employed + unemployed + not in labor force (excludes "not available" status)	51,434	51,451	54,473	51,000	52,452

Day Support is a psychosocial rehabilitative service that became available in FY 2002 for adults with serious mental illness. Day support, which is the least intensive psychosocial rehabilitative service, is a program of structured activities designed to support and enhance the role functioning of consumers who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Structured activities of the program are designed to maintain individuals in an environment less restrictive than inpatient or therapeutic residential treatment; develop daily living, social and other therapeutic skills; promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills; provide assistance in maintaining and learning new skills that promote independence; develop interpersonal relationships that are safe and wanted by the individual to eliminate social isolation; and, to improve physical and emotional well-being. Day support programs include, at a minimum, social skills training, group therapy, individual therapy, training in the use of leisure time activities, and coping skills training. The program must provide individuals with opportunities for varied activities, active and passive, and for individuals to make choices about the activities in which they participate.

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. Program content can vary, depending on individual strengths and needs, but must include close

observation/supervision and intensive support, with a focus on the reduction and/or elimination of acute symptoms. Acute partial hospitalization provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired.

Other Vocational Rehabilitation/Employment Services

DMH minimum standards require that transitional employment programs be available as part of clubhouse programs, which are available in all 15 CMHC regions. In addition to transitional employment programs offered by the CMHCs, individuals with serious mental illness have access to other VR services through referral(s) with VR service entities.

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 can, 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 Department of Mental Health 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 Mississippi Advancing Employment. Connecting People (APSE), which held its first conference in the state in September 2008. The 2nd *Annual MS APSE Conference: Opening Doors to Employment....Making it Happen* is scheduled for September, 2009.

Representatives of the Mississippi Department of Rehabilitation Services including the Director of the Selected Social Security Services Division at the Mississippi Department of Rehabilitation Services (MDRS) and coordinator of the Work Incentives Planning and Assistance project administered by MDRS, Mississippi Partners for Informed Choice (M-PIC), and the Ticket to Work Program have served as an additional resource for employment support. The Ticket to Work Program 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.

For the past nine years, the Mississippi Partners for Informed Choice (M-PIC) program has provided Work Incentives Planning and Assistance (WIPA) services to individuals receiving Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability. Work incentives planning and assistance services are provided free to these recipients through the program in order to enhance their ability to make informed choices regarding reentry into the workforce or entry into the workforce for the first time. M-PIC has Community Work Incentives Coordinators (CWICs) working in designated regions of the state who are available to comprehensively demonstrate the effect of wages on the SSDI/SSI recipient's disability benefits to dispel any unjustified fears of benefit loss due to work. The CWICs will work closely with the Social Security Administration, the Mississippi Department of Rehabilitation Services, other federal and state agencies and community service agencies, as needed, in order to maximize work incentives. Services under WIPA are designed to: analyze the impact of work and earnings on disability benefits; enhance individuals' ability to make informed choices in transitioning from benefits to work; identify work incentives to help achieve work goals; advise on how and when to use the Ticket to Work; assist in developing a plan for employment; coordinate with other agencies regarding a plan for employment; and, refer to other agencies that may provide additional supports to better enable the transition to work.

Given the potential benefit of services provided by the Mississippi Partners for Informed Choice to individuals with serious mental illness who are SSI and/or SSDI recipients, as well as the impact of the Ticket to Work Program changes, staff from the Mississippi Department of Mental Health and the Department of Rehabilitation Services, Division of Selected Social Security Services have partnered to provide a series of educational presentations on these rehabilitation services topics. MDRS staff will continue to make available information through presentations and exhibits for mental health staff and consumers. For their service areas, M-PIC staff provided training and educational information to local mental health center staff and individuals with mental illness throughout the state. DMH staff has facilitated linkage with MDRS staff to increase collaboration of local providers and consumer education programs as part of the agencies' outreach efforts. MDRS's Division of Selected Social Security Services staff look forward to continuing their partnership with the DMH to provide support services to individuals with mental illness.

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. Examples of specific Vocational/Employment/Educational Services provided to adults with serious mental illness, in addition to or in conjunction with vocational rehabilitation services and consumer education programs (described in previous objectives) in FY 2008 included: GED programs, literacy training programs, adult education programs, academic and vocational education, money management training, nutrition education, parenting education, computer literacy, tutoring programs, senior computer training, vocational education, financial assistance for education, single parent/displaced homemaker

services, college coursework, training in use of public transportation, training in activities of daily living, training in personal health management (e.g., health lifestyles, diabetes management, STD prevention) and consumer education programs.

The CMHCs, CMRC and the Community Services Divisions of the two larger state hospitals continued linkages with a variety of agencies in local communities that made these services available. Examples of individual agencies providing these types of support services in FY 2008 included: universities and community colleges across the state, local literacy councils/programs, Job Corps, family and community resource centers, public libraries, public school districts, county human resource offices, Recruitment and Training Program of Mississippi, county extension offices, local vocational-technical centers, Mississippi Protection and Advocacy System, Inc., the City of Jackson, Mississippi Department of Human Services, Headstart, WIN Job Center, Institute of Disability Studies (University of Southern Mississippi), private colleges, Families First program, a Community Action Agency, NAMI-Mississippi, and the Mississippi Department of Health.

Mental Health Transformation Activity: Improving Consumer Access to Affordable Housing and Supports

The issues of employment, housing and transportation are viewed as interrelated and must be addressed as necessary components of individuals' recovery, along with appropriate treatment, illness self-management and support. The need for additional adequate and affordable housing for individuals with serious mental illness is a major issue challenging the system and individuals' full recovery. The Directors of the Bureau of Administration and the Division of Community Services attended a technical assistance meeting in Memphis, Tennessee in August 2006 to learn more about the Tennessee housing program, which has developed approximately 5000 housing units for individuals with mental illness over approximately a five-year period. The person in Tennessee's state mental health agency who developed this housing initiative spoke at the Mississippi Annual Homeless Conference on December 8, 2006, and has shared their strategic plan and preliminary ideas with DMH staff. Additional visits to Tennessee are also planned to obtain information about details of the program design and implementation. The Division of Planning in the Bureau of Community Services has been participating in the NASMHPD Housing Task Force and will continue to network with potential partners at the state and local level and to seek specialized technical assistance to facilitate development of a strategic plan for housing for individuals with serious mental illness. These efforts are focused on developing strategies to better access any available federal program funds. The Mississippi Development Authority (MDA), which is responsible for developing the state's Five-Year Consolidated Plan for use of federal housing funds, has active representation on the Mississippi State Mental Health Planning and Advisory Council. The Division of Planning will also collaborate with and integrate the work of existing interagency groups addressing the needs of individuals with mental illness who are experiencing or at high risk for homelessness into work on a broader strategic plan for housing for persons with mental illness. (See also objective about interagency networking under Criterion 4).

Housing options currently provided through community mental health centers and the community services divisions of the state psychiatric hospitals include group homes, transitional residential programs (average stay of six months) and supervised apartments. Some housing assistance may also be available through public housing programs administered through local public housing authorities. The State Plan reflects the Department's goal of assisting individuals with serious mental illness in obtaining and maintaining independent living situations, in which they live on their own without supervision of daily living activities and are financially responsible for housing. Provision of a

comprehensive system of needed community-based mental health or other support services is vital in assisting individuals with serious mental illness in achieving this goal. The Mental Health Reform Act of 1997 included a provision promoting further development of community residential living services for persons with serious mental illness, including but not limited to group homes.

Group homes for adults with serious mental illness are homes shared by individuals in a community setting with 24-hour supervision. The program is designed to help individuals achieve more independence in a community living situation. In FY 2009, DMH certified 24 group homes for adults with serious mental illness (258 beds), including a new home opened by East Mississippi State Hospital, Division of Community Services in Kemper County. Additionally, DMH certified four homes (48 beds) operated by Central Mississippi Residential Center.

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

Objective: To continue to make group home options available in FY 2010

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of group homes

Indicator: Availability of 24 group homes.

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

PI Data Table A1.8	FY 2006 (Actual)	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Availability of Group Homes	25	23	23	24*	24

*See Special Issues (below)

Source(s) of

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

Special

Issues: A new halfway house opened by EMSH Community Services (Enterprise Home) was erroneously included in the count of certified group homes for the FY 2009 target, which was modified; therefore, no change in the number of group homes is projected from FY 2009 to FY 2010. The Amenity House (halfway house program) operated by EMSH Community Services was closed, so the total number of halfway houses (three) remained constant. (See the following objective.)

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

Funding: State and local funds

Transitional Residential Treatment Services or Halfway Houses for Adults with Serious Mental Illness provide a comprehensive residential treatment program to persons with serious mental illness and are specifically designed to serve individuals who are at high risk of hospitalization. Emphasis is placed on achieving stabilization, on developing and refining social and basic living skills, and acquiring other coping skills.

In FY 2009, as of April, DMH had certified three residential transitional programs in the state with a total of 34 beds, two of which are in the regions near the two larger state psychiatric hospitals (EMSH Community Services operated 10 beds (Enterprise), and MSH Community Services operated eight beds in Jackson), with the third in Greenwood (16 beds). Since most individuals are in transition to more independent or stable living situations, they typically stay in these residential treatment programs for six months or less.

Objective: To continue to make available transitional residential treatment/halfway house options for adults with serious mental illness in need of this service for FY 2010

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of transitional residential treatment options

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

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

PI Data Table A1.9	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 Target	FY 2010 Target
Transitional Residential Services #beds	33 beds	33 beds; 80 served	34 beds	30 beds	30 beds

Source(s) of

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

Special

Issues: None.

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

Funding: Federal, state and local funds

Supervised housing is a form of housing service that provides a residence for three or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a group home. Supervised housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day, consumers may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities. The persons living in the supervised housing service must be registered consumers of the provider program who have been determined to have a serious mental illness.

Supported living is designed to provide individuals some assistance while allowing them to maintain an independent residential arrangement. Supported living programs differ from “supervised apartments” in that supported living programs may have little or no involvement from the center in operation of the residence, support staff may not live in close proximity to the residence and contacts with consumers occur on a weekly or less frequent basis. The DMH Division of Community Services has continued to review the classification of existing supervised apartment programs, which has resulted in the reclassification of some beds. As of April 2009, DMH certified 13 supervised housing programs in six CMHC regions: Region 5 (capacity 30), Region 6 (capacity 32), Region 7 (capacity 55), Region 8 (capacity 8), Region 14 (capacity 12) and Region 15 (capacity 8; MSH Community Services had a capacity of 8 supervised housing beds.

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

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Supervised housing availability

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

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

PI Data Table A1.10	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Availability of Supervised Housing	153	153	153	150	150

Source(s) of

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

Special

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

in targets and/or reports are anticipated.

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

Funding: State and local funds

Other Housing Options

Community mental health service providers also continued efforts at the local level to access and/or expand community housing options for individuals with serious mental illness. Region 4 CMHC has been involved with four HUD-funded apartment projects, located in Corinth, Iuka, Ripley and Booneville, with a total of 18 apartments per site. Region 15 has been involved in a 17- unit project in Vicksburg. In Region 6, 14 HUD apartments serve 16 individuals (two of the apartments are two-bedroom units); NAMI-MS is collaborating on a HUD project planned for Lexington, which is also in Region 6.

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

DMH continued work in FY 2009 to develop capacity to collect data for evidence-based practices by the FY 2010 timeline. The federal definition of “supported housing” as an evidenced based practice as proposed in URS Developmental Table 16 is similar to what is referred to in Mississippi as “supervised living.” DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported housing. DMH is continuing work on developing capacity for collection of information, for reporting evidence-based practices (such as supported housing) and for improving data integrity for the National Outcome Measures, with support from the CMHS Data Infrastructure Grant (DIG) for Quality Improvement.

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

Goal: To continue support and funding for existing programs providing outreach and coordination of services to individuals with serious mental illness who are homeless/potentially homeless.

Target: To continue support and funding for existing programs for individuals with serious mental illness who are homeless/potentially homeless.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

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

Measure: Number of adults reported in homeless/in shelters as a percentage of adults served in the

public community mental health system

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

Special Issues: According to Uniform Reporting System Guidelines for Table 15 (Living Situation), the number of adults who are homeless/in shelters within all DMH-certified and funded community mental health programs are reported, including specialized programs funded through the federal Projects for Assistance in Transition from Homelessness (PATH) program. Therefore, the percentage of adults who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of adults served by these specialized programs occur. DMH is continuing work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR and ongoing efforts to improve data integrity might result in adjustments to baseline data, therefore, trends have been tracked for another year (in FY 2009) to better inform target setting in subsequent Plan years.

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

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% of adults reported homeless/in shelters	.8%	.7%	.8%	.7%	.78%
Numerator: # adults reported					

homeless/in shelters by DMH certified/funded providers	509	402	512	402	474
Denominator: # adults reported with living situations by DMH certified/funded providers, excluding persons with living situation Not Available	60,048	59,625	63,410	59,625	61,028

Substance Abuse Services

As indicated in the Children's Services Plan, substance abuse services are also administered by the MS Department of Mental Health through its Bureau of Alcohol and Drug Abuse (DADA), which is located in the same bureau as the Division of Community Services (for adults). Community mental health centers are the primary providers of both community mental health and outpatient substance abuse treatment for adults. Specific objectives addressing the needs of individuals with a dual diagnosis of mental illness and substance abuse are described in the following section under this Criterion on Activities to Reduce Hospitalization/Rehospitalization, since alcohol use has been found to be a major factor in individuals returning to the hospital. The existing substance abuse treatment system components administered by the Bureau of Alcohol and Drug Abuse that address the needs of adults are described below:

Substance Abuse Services for Adults and Children

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

General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided these services. One of the free-standing programs, Metro Counseling Center provides day treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care. At the conclusion of FY 2008, there were 10,377 individuals who received these services.

Intensive Outpatient Services: These services are directed to persons who need more intensive care but who have less severe alcohol and drug problems than those housed in residential treatment. IOP services enhance personal growth, facilitate the recovery process and encourage a philosophy of life which supports recovery. These services are provided by 11 community mental health centers, 11 certified free-standing programs and one adolescent program, CARES Center/ the Ark. In FY 2008, there were 1,412 individuals who received these services.

Chemical Dependency Unit Services: Inpatient or hospital-based facilities offer services to these individuals with more severe substance abuse problems and who require a medically-based environment. Treatment includes detoxification, individual, group and family therapy, education services and family counseling. BADA continued to make available funding to 4 certified programs and 1 adolescent program which is the Bradley Sanders Complex, an extension of East MS State Hospital. At the close of FY 2008, there were 1,138 individuals who received these services.

Primary Residential Services: These services are for persons who need intensive residential treatment who are addicted to alcohol and drug problems. Services are easily accessible and responsive to the needs of the individual. In residential treatment, various treatment modalities are available, including individual and group therapy; family therapy; education services; vocational and rehabilitation services; recreational and social services. Adolescents who need primary residential treatment for alcohol and drug problems are provided intensive intervention. Individual, group and family counseling are offered as well as education programs at the appropriate academic levels. Adults and adolescents with a co-occurring disorder of mental illness and substance abuse are also provided treatment in a primary residential setting. These services are provided by 14 community mental health programs, 11 certified free-standing programs and 3 adolescent programs. In FY 2008, there were 3,338 adults and adolescents who received these services.

Transitional Residential Services: These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program before being eligible for admission to a transitional residential program. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2008, there were 827 adults who received these services.

Outreach/Aftercare Services: Outreach services provide information on, encourage utilization of, and provide access to needed treatment or support services in the community to assist persons with substance abuse problems or their families. Aftercare services are designed to assist individuals who have completed primary substance abuse treatment in maintaining sobriety and achieving positive vocational, family and personal adjustment. These services are provided by 14 community mental health centers, 21 certified free-standing programs and 1 adolescent program. In FY 2008, there were 4,166 individuals who received these services.

Referral Services: During FY 2009, the Bureau of Alcohol and Drug Abuse updated and distributed the current 2009-2010 edition of the Mississippi Alcohol and Drug Prevention and Treatment Resources directory nationwide. The directory is also on the DMH Internet web site for those in need of services.

During FY 2008, the Office of Constituency Services received and processed approximately 2,378 calls requesting substance abuse information or assistance in finding treatment and/or other related/support services. Over 24 categories of “problems/needs” were addressed.

Employee Assistance Program: During FY 2008, The Employee Assistance Coordinator updated and distributed the Employee Assistance Handbook to representatives of state agencies and organizations. The handbook entails the development of an employee assistance program including federal and state laws regarding a drug free workplace. The coordinator continued to provide EAP trainings across the state.

Specialized/Support Services: These services include vocational rehabilitation which is provided to individuals in local transitional residential treatment programs through a contract between the Bureau of Alcohol and Drug Abuse and the Department of Rehabilitation Services. In FY 2008, vocational services were provided to 124 individuals. Other specialized/support services include providing treatment to individuals who have been diagnosed with a co-occurring disorder of mental illness and substance abuse. All 15 community mental health centers provide co-occurring services through SAPT block grant funds. The Bureau of Alcohol and Drug Abuse continued to provide funding to one of the state-operated psychiatric hospitals to manage a 12 bed group home for co-occurring individuals. In FY 2008, 10,991 individuals with a co-occurring disorder of mental illness and substance abuse were served. The substance abuse treatment system also includes special programs or services designed specifically to target certain populations such as women and children, DUI offenders and state inmates. At the close of FY 2008, there were 2,656 individuals who were admitted to a DUI program and 1,698 inmates admitted to the residential alcohol and drug abuse treatment program at the state penitentiary.

Private Resources

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 301 licensed and/or Certificate of Need (CON) approved beds in FY 2008 for adolescents. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

Health/Medical and Dental Services/Other Support Services

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. Specific examples of medical/dental services reported as provided/accessed in FY 2008 by individual CMHCs and the Community Services Divisions of the state psychiatric hospitals included: general outpatient medical services (including free walk-in clinics in some areas), prevention services, home health services, STD testing, emergency services, inpatient services, OB/GYN services, TB screening, podiatry, neurology services, psychiatric services, immunizations, medical detoxification services, hospice care, nutrition services, prescription assistance programs, vision care, general dental care (routine examinations and cleaning), emergency dental care, and preventive dental care.

In FY 2008, specific examples of local providers through which services were accessed included federal Community Health Centers (CHCs), local county Health Department offices, rural health clinics, home

health agencies, medical testing agencies, local county and/or community hospitals, private psychiatric hospitals, local private practitioners (medical, dental and orthodontics), local private practice clinics, free clinics, Voice of Calvary, University of Mississippi Medical Center, local faith-based organizations, the Veteran's Administration, the University of Tennessee School of Dentistry, MCC School of Dental Hygiene, and the University of Mississippi Medical Center, School of Dentistry. Mississippi Medicaid provides palliative dental services only for adult beneficiaries, age 21 and over. Palliative services are defined as the treatment of symptoms without treating the underlying cause. Palliative care includes emergency care for the relief of pain and infection, but it does not include preventive and restorative care.

As mentioned, outpatient health and medical care is also available through federally funded Community Health Centers in the state. There are 21 Community Health Centers with over 152 delivery sites in Mississippi, further advancing President Obama's effort to provide access to health care for all Americans. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale. However, no one is refused care due to inability to pay for services. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, fulfilling President Obama's Growth Initiative for Community Health Centers. 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 also makes available certain specialized health care programs, such as: Home Care Services for homebound individuals requiring intermittent professional health services while under a physician's care; WIC, the Special Supplemental Nutrition Program for Women, Infants and Children; the Breast and Cervical Cancer Early Detection Program, offering screening to uninsured, underinsured and minority women within specified age ranges for screening; the Domestic Violence/Rape Prevention and Crisis Intervention Program, providing resources through contracts with domestic violence shelters and rape crisis programs, including educational resources; the Family Planning Program; Maternity Services, targeting pregnant women whose income is below 185% of poverty and including special initiatives such as the Perinatal High Risk Management/Infant Services System and the Pregnancy Risk Assessment Monitoring System (PRAMS).

As described previously, in order to receive CMHS funds and other funds administered by the DMH, all 15 mental health centers are required to develop a plan for providing community support services. This plan is developed using an outline of components that includes a requirement for local programs to describe how the program assures that consumers in all geographic areas have access to medical/dental services, how those services are paid for and how those services are provided in a timely manner. When the plans are submitted, they are evaluated by a committee convened by DMH, which includes family members, and corrections must be made until the state is satisfied that the plan adequately addresses requirements in the plan guidance. Annually, each CMHC submits a plan for providing medical, dental and other support services as part of their community support programs plan, which is required as part of the centers' application for CMHS Block Grant funds. In FY 2009, the Department of Mental Health

continued to require that the 15 community mental health centers implement plans for providing medical, dental and other support services. This plan is submitted to the DMH with the services providers' CMHS Block Grant funding request. The community mental health centers maintain a list of resources to provide medical/dental services, such as general health services, inpatient hospital, preventative, family support immunizations, TB screening, home health services, psychiatric evaluations/medication monitoring and communicable disease evaluation. The Department of Mental Health will continue this requirement in FY 2010.

Social Services

Social Services and Financial Assistance are available through programs administered by the Mississippi Department of Human Services (DHS) 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/support, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The 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 Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program, Health Marriage Initiative, Supplemental Nutrition Assistance Program (SNAP), the Emergency Food Assistance Program (TEFAP), SNAP Nutrition Education, and the "Just Wait" Abstinence Education program. 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 Child Support provides child support location/enforcement services, and non-custodial visitation programs. 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 is scheduled to expand 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 the Fatherhood initiative, 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.

Mental Health Case Management Services

Target Population: The following individuals with serious mental illness must be evaluated for the need for case management and provided case management if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated:

- Adults who have a serious mental illness and who receive substantial public assistance (defined as Medicaid); and,
- Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility.

Model of the Case Management System

The philosophy of the Mississippi Department of Mental Health Case Management System is that the provision and coordination of services are an integral part of aiding eligible recipients to gain access to needed medical, social, educational, and other services in order to reach and maintain their highest level of independent functioning. The purpose of Case Management is to assist the consumer in achieving and maintaining the highest possible degree of personal growth, autonomy, and community integration. Responsiveness to persons with severe mental disabilities is maximized through a supportive relationship with a case manager. Inherent in this philosophy are the following principles:

Entitlement: Persons with serious mental disabilities are entitled to full participation in their communities such that their learning, growth, and independent functioning are maximized. The Case Management System helps to secure resources in important life domains essential for human growth and development (housing, life skills, social support, employment, education, health/mental health, and leisure/recreational activities).

Empowerment: Interventions are based on consumer self-determination. In order to increase individual self-determination, services are planned with the participation of the consumer. The focus is placed on consumer-driven strengths, unique goals, needs, advocacy, and the natural support system.

Environment: The success of case management lies in the case manager's ability to provide an environment conducive to meeting the consumer's psychosocial needs. Focus is changed from problems and pathologies to identifying individual strengths and personal aspirations, which is the foundation for service planning. The case manager must bring to the relationship the attributes of warmth, acceptance, empathy, caring, concern, and genuineness in order to promote a supportive environment and to provide the consumer with a sense of security and support needed to move closer to identified goals. An important role of the case manager is to provide consumers with the freedom to be their own persons and thereby grow from their own choices.

Relationship: One of the most important variables in successful case management is the relationship of the case manager and consumer. Consumers must know their case manager, trust them and see them as an advocate. The relationship is viewed as two adults taking responsibility for identifying needs, setting goals, and citing accomplishments, and serves as a buffer to minimize periods of stress.

Community: The community is conceived as a network of resources available to improve the consumer's environment. Case management accesses an extensive array of service, links the person to the community and to public and private service providers, along with coordinating available

resources to increase the consumer's quality of life in all areas.

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case management service provision

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

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

PI Data Table A1.12	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
# Served–Case Management	17,416	16,781	15,331	15,500	15,500

Source(s) of Information: Annual State Plan Survey

Special Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG), to develop a central depository for data from the mental health system. As this system is implemented within the FY 2008-2009 time period, downward adjustments in targets are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed

Significance: The DMH requires all CMHCs and community services divisions of the state psychiatric hospitals to provide case management services. It is recognized by the DMH that case management services provide valuable linkage and assistance through the community integration/participation process as well as diversions from hospitalization, particularly for those individuals with high inpatient recidivism rates.

Funding: State, SSBG, Medicaid, local funds

In FY 2009, case management records continued to be reviewed for meeting the requirement to evaluate adults with serious mental illness who receive substantial public assistance for the need for case management services. As of March 2009, 100% of the records reviewed reflected that this requirement had been met, that is, that individuals with serious mental illness receiving substantial public assistance

had case management explained, offered and refusals placed in writing.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case Management: Medicaid eligibility/service referral

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

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

Source(s) of

Information: DMH Site Visit Documentation (review of records)

Special

Issues: None

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

Funding: State, SSBG, Medicaid, local funds

Intensive Case Management

In FY 2000, the DMH began offering technical assistance to CMHCs interested in offering the levels system of case management. The levels system is based on the concept of consumers moving through levels of assistance and support based on their changing needs and levels of independence. The concept underlying a levels system is that higher levels of intensity of case management services would correspond to smaller caseloads for case managers and a higher degree of involvement with consumers. Since FY 2000, a significant portion of Mississippi's CMHS Block Grant increases have continued to be allocated to the 15 community mental health centers for providing intensive case management services for adults with serious mental illness. These CMHS Block Grant funds further support staff and expenses for providing intensive case management services to individuals with serious mental illness being considered for inpatient treatment. The funds also support community mental health center staff maintaining supportive contact with consumers and participating in hospital discharge planning to assure a smooth transition from inpatient to community services settings.

Staff who are providing intensive case management are also available to work closely with staff of new state crisis centers as they become fully operational. The intensive case manager from Regions 2, 4, 5, 6, 10 and 12 contact the crisis center staff weekly, either face-to-face, by teleconference, or by telephone to work proactively with the center’s social work and other staff at the crisis center. The intensive case managers in all 15 regions will also continue to consult with the hospital staff at North MS State Hospital, MS State Hospital, South MS State Hospital and East MS State Hospital regarding discharge planning, ongoing support, training and assistance in developing a range of community and family supports. The overall goal of the crisis center staff and the intensive case manager is to reduce the need for unnecessary hospitalization whenever possible and to improve the consumers’ quality of life. Also, use of CMHS funds for the provision of intensive case management enhances continuity of care. As of April 2009, due to reductions in federal CMHS Block Grant funding, grant awards for each provider of services were reduced by \$1000; however, each program continues to provide intensive case management.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Intensive case management support/assistance

Indicator: Continued availability of funding from DMH to support intensive case management.

Measure: The number of CMHC regions to which DMH makes funds available to support intensive case management (15 CMHCs)

PI Data Table A1.13	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
CMHCs Funded for Intensive Case Management	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Source(s) of

Information: Program grants and Monthly Summary Form.

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

Funding: CMHS Block Grant

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

Technical Assistance to Case Managers

Technical assistance for case management services for adults with serious mental illness is available through a designated staff member of the DMH Division of Community Services and through the Case Management Task Force, which meets to discuss changes and improvements to the system. As mentioned previously, training on Person-Centered Planning will continue to be incorporated into meetings of the Case Management Task Force and Case Management Orientation. As of April 2009, two Case Management Task Force meetings had been held; they assisted the Division of Community Services in developing the components of a proposal for a Medicaid State Plan Amendment, and they reviewed/concurred with positive changes in the Professional Licensure and Certification programs. The task force received inservice training (*Completing the Puzzle: Interpreting and Enhancing Differential Diagnosis of Selected Mental Health Disorders*, presented by Dr. John Norton, Director of the Medical Psychiatric Unit at the University of Mississippi Medical Center). They also participated in a brainstorming/feedback session on “Redesigning and Developing Transportation Services for Persons Living with Disabilities: A Statewide Approach” (facilitated by Jan Larsen of Global Strategies, Inc.).

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case management support/assistance

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

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

Source(s) of

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

Special

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

Significance: Given the vital role played by case managers in the service system, the recent development of new case management service options and the ongoing provision and expansion of case management training programs, addressing technical assistance

and program improvement in case management programs, focusing on a recovery-oriented approach, remains a priority of the DMH Division of Community Services.

Funding: State and local funds

Case Management Outreach

In FY 2009 and 2010, the Department of Mental Health will continue to disseminate brochures about case management to the community mental health centers and Community Services Divisions of MS State Hospital and East MS State Hospital for use in public education/out reach activities. Brochures will also be disseminated during Case Management Orientation, the Annual Conference on Homelessness and local community health fairs, conferences and training opportunities.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Public awareness of case management

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

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

Source(s) of

Information: DMH records of distribution of brochures

Special

Issues: None

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

Funding: State funds

Mental Illness Management Services (MIMS) and Individual Therapeutic Support are two case management services that became available in FY 2002.

Mental Illness Management Services (MIMS) include case management activities that may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the consumer live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional

expertise/skill of the provider of these services, required by the more complex mental health needs of some individuals with serious mental illness. MIMS may be provided in any appropriate community setting by a staff member who holds at least a Master's degree (in an appropriately related field) and professional license (for example, as a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Master's level Social Worker or a physician) or who is a Department of Mental Health Certified Mental Health Therapist.

Individual Therapeutic Support is the provision of one-on-one supervision of an individual with serious mental illness during a period of extreme crisis, without which hospitalization would be necessary. The service may be provided in the individual's home, school or any other setting that is part of his/her environment. Individual therapeutic support focuses on the reduction/elimination of acute symptoms and is provided during a time when the individual is unable to participate in regular treatment activities, such as partial hospitalization or day treatment. This service must be provided by a staff member with at least a high school or equivalent degree who has completed certification approved by the Department of Mental Health.

See also objective on Case Management Training and objective on development of the Case Manager Certification Program under Criterion #5 that follows.

Activities to Reduce Hospitalization

Factors Associated with Rehospitalization

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.

Research conducted in Mississippi over ten years ago by Dr. Greer Sullivan, M.D., M.P.H., of the Rand Corporation, provided early information on major risk factors associated with rehospitalization of individuals from the Mississippi State Hospital, the larger of the state psychiatric facilities. The study was related to a conceptual model of rehospitalization in which several categories or risk factors for hospital recidivism were considered, including severity of illness measures, and patient system/access to care factors (Sullivan, October, 1987). Major "risk factors" identified included: (1) medication non-compliance, (2) current alcohol abuse, (3) family conflict, and (4) low use of CMHC services. Descriptions of existing services and objectives for FY 2009 o divert individuals from hospitalization and/or reduce the risk of rehospitalization follow in this section.

Although all community-based services are aimed at preventing hospitalization, when possible, and reducing the rate of rehospitalization, some specific services are key components of community-based systems used as alternatives to inpatient treatment in the event of a crisis, as well as follow-up services once crisis situations have been stabilized. These services, as well as efforts to improve the emergency response/crisis management systems in the state, also address medication compliance, co-occurring alcohol abuse, the role of families, and use of CMHC services, factors found in Sullivan's study to be associated with rehospitalization of individuals with serious mental illness.

Pre-evaluation Screening for Civil Commitment services, a major purpose of which is to reduce the number of inappropriate admissions to the state psychiatric facilities, is available through all 15 CMHCs. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for referral to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals. During FY 1995, the state expanded this service to include a process for a single point pre-evaluation screening for commitment examinations. This process was established by legislation through changes in the state's civil commitment law during the 1994 legislative session.

The civil commitment process requires that the local CMHC conduct a pre-evaluation screening for the Chancery Court to use to determine if the commitment process (including examination for inpatient or outpatient commitment) should continue. The pre-evaluation screener also provides useful information or other information about available community services for the Court's consideration, if alternatives to inpatient commitment are appropriate. If the court determines there is a need to continue with the involuntary commitment process, the consumer is evaluated by two physicians or one licensed physician and one licensed and certified psychologist. The commitment examination is to determine if commitment should be made, either for inpatient or outpatient services.

The Department of Mental Health began making available training and certification to staff conducting pre-evaluation screening in April 1995. Implementation of the change in commitment law that requires single-point (CMHC) pre-evaluation screening of individuals being considered for civil commitment and the subsequent training, facilitates better coordination among the Courts, CMHC staff, and Court-appointed examiners throughout the referral, screening and examination process. The process was also designed to facilitate the consideration by Courts, providers, and affiants of treatment alternatives less restrictive than inpatient care during mental health crises situations. It is also hoped that these changes in the process will result in making the commitment process more standard (and thereby less difficult for consumers and families to navigate) across jurisdictions.

The DMH has continued to require the pre-evaluation screening training of community mental health center staff who conduct pre-evaluation screening. Doing so creates a uniform system and facilitates communication and coordination between the CMHC staff conducting the pre-evaluation screening the courts and family members.

The Department of Mental Health *Minimum Standards for Community Mental Health/Mental Retardation Community Services* require that certified community mental health centers have written policies and procedures for referral to inpatient services in the community, should an individual require such services. According to DMH minimum standards, providers must have current written agreements with licensed hospitals on file that: identify the mental health program's responsibility for the consumer's care while he/she is in an inpatient setting; describe the services the hospital will make available to individuals who are referred; and, describe how hospital referral, admission and discharge processes are coordinated with emergency, pre-evaluation screening, and aftercare services.

Emergency Response/Crisis Management Services

The two major components of existing emergency services available through the 15 CMHCs are a crisis telephone service and when needed, availability of face-to-face contact with a mental health professional. Through the emergency service component, individuals for whom outpatient services are inadequate are often identified. Community mental health centers maintain agreements with local hospitals which, within certain restrictions, are able to treat individuals in lieu of admission to the state

hospital. CMHCs might provide professional back-up to hospital staff to further ensure appropriate care. These agreements, however, are in many instances limited. For example, in some regions, the agreement is for general hospital beds on a priority basis, but the beds are in a general ward and no psychiatrist is on the hospital staff. In these instances, the admission is made by a local private physician, and the mental health center staff work with the physician on a consulting basis. Recognizing that inpatient care is limited because of a lack of psychiatrists and available psychiatric beds and that inpatient hospitalization can be avoided in many if not most instances if intensive crisis intervention services are readily accessible, the DMH has initiated development of crisis services across the state.

Regional Acute Care/Crisis Stabilization System

To address the need for more immediate access to emergency or crisis services, including acute hospital and crisis stabilization services closer to consumers' home communities and their families, the State Legislature has funded major components to build a regional system. Implementation of these components are aimed at reducing hospitalization and rehospitalization of individuals with serious mental illness, when appropriate to their needs. These efforts also address the issue of waiting lists for admission to the larger existing state hospitals at Meridian (East MS State Hospital) and at Whitfield (Mississippi State Hospital). Inpatient services for adults with serious mental illness are currently available statewide through two comprehensive state psychiatric hospitals (Mississippi State Hospital, which historically has served 51 counties, and East Mississippi State Hospital, which has served 31 counties) and on a limited basis through local public or private hospitals. The more recently developed North MS State Hospital and South MS State Hospital provide acute psychiatric services for adults. (See Regionalization of Acute Hospital Services that follows.) As described in Section I, East MS State Hospital and Mississippi State Hospital provide a range of services including: acute psychiatric care, intermediate psychiatric care, continued treatment, alcohol and drug treatment, and some community services. Mississippi State Hospital also operates medical surgical hospital services and forensic services, which provide pretrial evaluations and treatment of criminal defendants. Licensed nursing facility (home) services are also operated on the grounds of both hospitals. The goal of both Mississippi State Hospital and East Mississippi State Hospital is to make available quality inpatient services for individuals in need of this level of care, when such services are not available at the local levels.

Regionalization of Acute Hospital Services

The State Legislature funded construction of two, new 50-bed acute adult psychiatric hospitals for adults: the North Mississippi State Hospital opened in April, 1999, in Tupelo, in Lee County, currently serving 14 counties (from MSH's service area) in CMHC regions 2 and 3, and four counties (from EMSH's service area) in CMHC Region 4. The designated service areas for the South Mississippi State Hospital, which serves adult men and women, include the nine counties in the Region 12 Pine Belt Mental Healthcare Resources and, as beds are available, from two counties in Region 13 (Pearl River and Stone) and individuals from other counties in the southern part of the state who may be awaiting services at another state hospital. These two hospitals are designed to provide more immediate access to emergency and acute stabilization services, which are anticipated to reduce the need for longer-term stays or continued treatment at the two larger state hospitals in Meridian and Whitfield. Services provided through these two units are coordinated with community mental health center services in their respective regions to facilitate continuity of care before admission and after discharge, thereby further reducing the need for rehospitalization.

Regionalization of acute care/crisis stabilization services closer to individuals' home communities will facilitate families' participation in consumers' treatment and transition from the hospital. As these regional service options become available, it is anticipated that the need for continued treatment beds at the two larger existing hospitals will be further reduced. In FY 2008, the number of adults receiving services at the state adult psychiatric hospitals was 3,524 (excludes other services provided by MSH and EMSH): EMSH –354; MSH –451; NMSH - 354 and SMSH –344. (See also total public mental health system and community mental health system data under Criterion 2 that follows.)

Community-Based Emergency Services Systems Development

Crisis Centers:

Provision of more immediate access to crisis services for short-term emergency mental health treatment, for serving persons awaiting commitment proceedings or awaiting placement in a state mental health facility following commitment and for diverting placement in a state mental health facility was a major provision in the 1997 Mental Health Reform Act (SB 2100). Also included in the legislation was a provision to establish regional state offices to provide mental health crisis intervention centers and services to be used on a case-by-case emergency basis. To support service options that address these provisions, the State Legislature and the Governor approved additional funding in the 1999 Regular Session as follows:

- The 1999 State Legislature provided funding through Senate Bill 3119 for construction of seven community-based crisis centers to be operated as satellites of existing and new facilities operated by the Department of Mental Health.

- The 2004 State Legislature appropriated funds to open the center in Corinth at full capacity in FY 2005. (The Corinth Center had operated at partial capacity for most of 2003 and 2004 because of funding constraints.) Funds were also appropriated in 2004 to open the five remaining centers that are constructed (in Newton, Grenada, Laurel, Cleveland and Batesville) at partial capacity in FY 2005. In FY 2006, funds were authorized for full operation of the six crisis centers that are constructed in FY 2007 and funds were authorized for operation of the seventh crisis center in Brookhaven in FY 2008. In FY 2008, 1041 adults were served by the seven crisis centers.

All of the seven centers constructed or planned are of similar design and function. The anticipated role of these centers in the regional system is to provide stabilization and treatment services to persons who are in psychiatric emergencies, including those who have been committed to a psychiatric hospital and for whom a bed is not available. It is believed that many of these individuals can be treated in the center and returned to the community without an inpatient admission to the psychiatric hospital. The more quickly a person is treated, as opposed to being "held" without treatment, the less likely his or her condition will worsen. Therefore, successful treatment can be accomplished in less time, even if the person still needs to be admitted to the hospital. Other individuals will not need to be hospitalized at all. The centers are located near or have easy access to a medical facility that will accommodate medical emergencies. For example, the crisis center that is operational in Corinth is located adjacent to the Magnolia Hospital. In addition, plans include establishment of a cooperative relationship with a medical emergency facility so that medical clearance can be obtained for persons who have symptoms that may be indicative of both psychiatric and medical conditions. Security will also be a prime consideration, given that some persons served by the centers may be suicidal,

violent or aggressive. Each of the three units or “wings” of the facility are designed to be equipped to provide for telemedicine to provide any needed professional consultation/support from the regional hospital/center and potentially, from the University Medical Center in Jackson, MS.

Programming components include: crisis stabilization; assessment/evaluation/observation, which should be accomplished within five days to determine recommendations for further treatment, either at the center or an alternate location; group, patient and family education; individual case management; small group discussions; recreational activities; alcohol/drug education; individual crisis counseling; and discharge planning. After treatment in the crisis centers, hopefully individuals will be able to remain in their home communities, where they can be linked with community mental health services and supports if needed. If individuals are in need of additional intensive services at an inpatient facility, they may be referred to that level of care. Efforts will be made to maintain continuity of care through linkage with service providers, regardless of the type services needed.

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

Intensive Case Management

Since FY 2000, the DMH has continued support (including support from the CMHS Block Grant) of the development of comprehensive emergency services systems, of which intensive case management is an important component. In FY 2008 and FY 2009, the DMH continued the support of comprehensive emergency service systems, of which intensive case management is an important component.

Intensive Residential Treatment Programs

Additionally, the DMH has continued to provide funding to help support three intensive residential treatment programs for adults with serious mental illness in crisis, operated in Vicksburg, by Region 15 CMHC (Warren-Yazoo Mental Health Services), in Gulfport by Region 13 CMHC (Gulf Coast Mental Health Center), and in Greenwood by Region 6 CMHC (Life Help). Region 6 (based in Greenwood) continues to operate a five-bed intensive residential treatment center. Region 13 (based in Gulfport) continues to operate an intensive residential treatment facility in Harrison County. Region 15 (Vicksburg/Warren Counties) opened its intensive residential treatment facility in Vicksburg in July, 1998, initially taking voluntary admissions. In October, 1998, they also began serving individuals who had been or were involved in the civil commitment process. The intensive residential treatment facility provides the residential component, while Warren County provides the holding facility component in a separate location. Since opening, the intensive residential treatment facilities in Region 13 and Region 15 have reported a positive impact on diverting individuals from state psychiatric hospital admission. In FY 2004, the programs served 550 individuals. The program in Region 13 closed in August 2005 because of damage caused by Hurricane Katrina, but resumed providing services at partial capacity (temporarily certified for 16) in temporary facilities in November 2005. By the end of FY 2006, Region 13 had repaired and reoccupied the building for its intensive residential facility, but was operating at partial capacity because of staffing difficulties remaining following Hurricane Katrina. In FY 2007, the program resumed operating at full staffing/capacity. As of April 2009, the three intensive residential programs had served 548 individuals in FY 2009: Region 6 served 98 people, Region 13 served 408 people, and, Region 15 served 78 people. (Support of these intensive residential treatment programs is in addition to the seven crisis intervention centers operated or under development by the

DMH and described in the previous objective.)

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Crisis/intensive residential programs

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

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

PI Data Table A1.15	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 Target	FY 2010 Target
Funding – Intensive Residential Programs	3 CMHC Regions*	3 CMHC Regions	3 CMHC Regions	3 CMHC Regions	3 CMHC Regions

*Because of the impact of Hurricane Katrina, the program operated by Gulf Coast mental Health Center (Region 13 CMHC) was severely damaged. Subsequently, Region 13 re-opened in temporary facilities at the end of November 2005, but the facilities were operating at partial capacity because of staffing issues experienced at that time. The program began operating at full capacity again in FY 2007.

Source(s) of

Information: Program Grants and Residential Monthly Summary Forms

Special

Issues: None

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

Funding: State and local funds

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

Assertive Community Treatment is an evidence-based practice included in the CMHS Core Performance Indicators, the proposed definition of which differs from intensive case management, but which also includes a target population of individuals with more severe and persistent challenges. As mentioned previously, the Person-centered Planning project implemented in four regions targeted individuals at risk for hospitalization or rehospitalization, and is exploring using a more team-oriented approach to transition planning, which is one element of the proposed federal definition of Assertive

Community Treatment. In May 2005, staff from the DMH Division of Community Services attended the Annual Assertive Community Treatment (ACT) Conference in Tampa, Florida.

Technical assistance on ACT was provided in 2006, through support/collaboration with NAMI-MS; the role that peer specialists might play in provision of ACT services has also been explored. Since that time, DMH Division of Community Services staff has visited with staff of the VA Hospital's ACT team in Jackson. Staff from Region 15's community mental health center have visited the ACT team in Little Rock, Arkansas (in March 2007), and the DMH sent a team (that includes regional staff that participated in the PCP project) to Oklahoma at the end of FY 2007 to obtain additional, follow-up technical assistance regarding implementation of ACT. Since that time, an ACT Steering Committee has been established to continue work on development of ACT and efforts have continued to seek funding support for ACT teams. DMH continued activities through its Data Infrastructure Grant (DIG) Quality Improvement project to develop the capacity of the central data repository system for data collection and reporting of evidenced based practices, such as assertive community treatment.

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

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

As mentioned previously, a major risk factor identified in a study of factors associated with rehospitalization of individuals with serious mental illness was current alcohol use. Implementing a strategic plan to better address the needs of individuals with co-occurring disorders of mental illness and substance abuse is a major task in system transformation efforts. The DMH has pursued initiatives to improve services in this area for many years; most of those efforts were coordinated by what was formerly the Dual Diagnosis Task Force, which was restructured to become the Co-occurring Disorders Coordinating Committee. The group has functioned to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse and sponsored an annual conference addressing specific training issues in this area for both adults and children and developed program guidelines for grants to local providers to provide specialized services for individuals with dual diagnoses.

In April 2005, the DMH received technical assistance from the Center for Excellence on Co-occurring Disorders, sponsored by SAMHSA, which focused on issues pertinent to service planning for adolescents and young adults with co-occurring disorders. Following that initial two-day visit, DMH's planning efforts were expanded to address the need for a more comprehensive, integrated systems approach across all age groups. As part of that effort, the DMH provided inservice training to state office staff and disseminated SAMHSA's TIP-42 to substance abuse and mental health community services providers throughout our state. In February 2006, DMH utilized its Annual State Conference on Co-occurring Mental Health and Substance Related Disorders to further engage additional stakeholders in planning efforts and to advance knowledge in the field about the evidence for service integration. These focused activities over approximately one year culminated in the development of a draft Strategic Plan for Co-occurring Disorders, developed by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative. The group drafted the plan through a two and a half-day intensive planning session in the Spring of 2006, facilitated once again by the COCE. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded.

The Co-occurring Disorders Coordinating Committee was reconvened in FY 2007 to review, refine and address objectives in the plan. Plans are to expand the membership to include additional individuals receiving services and family members. The committee includes representatives of DMH's Divisions of Adult Community Services, Children and Youth Services, Alcohol and Drug Services and Planning, as well as representatives of community services providers and an individual who has received services. Since SAMHSA's Co-occurring Disorders Center for Excellence (COCE) has effectively assisted the state over the last two years, additional technical assistance from COCE and was received beginning in the summer of 2007 to continue progress on implementation of evidence-based integrated service models for the remainder of FY 2008 and FY 2009. The Co-occurring Disorders Coordinating Committee met in April 2008 and has developed subcommittees on workforce development, treatment plan training and screening and assessment. A committee member attended a national training program on TIP 42, and three committee members plan to attend training on the GAIN (standardized assessment instrument). In FY 2009, statewide training sessions were initiated to facilitate implementation of integrated treatment for persons with co-occurring disorders. As of April 2009, staff from Region 12 (Pine Belt Mental Healthcare Resources) was providing consultation, training, and clinical coaching on co-occurring disorders to all 15 community mental health regions. Formal training is being offered on assessment, reporting of diagnosis, and treatment planning for individuals with co-occurring disorders, and including evidence-based practices for providing services to individuals with co-occurring disorders and effective clinical supervision for enhanced clinical outcomes. To date, training has been provided in four regions. As of February 2009, a standardized screening instrument, the GAIN, has been implemented in all regions.

Objective: The Co-occurring Disorders Coordinating Committee will continue to meet and make recommendations regarding service delivery and/or training.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Co-occurring Disorders Coordinating Committee Operation

Indicator: Continued operation of the Co-occurring Disorders Coordinating Committee, which will focus on strategies for improving services to adults with co-occurring disorders of serious mental illness and substance abuse.

Measure: The Co-occurring Disorders Coordinating Committee will continue to meet and report to the MS State Mental Health Planning and Advisory Council on its activities, at least annually.

Source(s) of

Information: Co-occurring Disorders Coordinating Committee minutes

Special

Issues: None

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

Funding: SAPT block grant and state funds

In FY 2008 and FY 2009, funds were provided to continue support for operation of a 12-bed community-based residential facility for individuals with a co-occurring disorder of serious mental illness and substance abuse by the Division of Community Services at Mississippi State Hospital.

Objective: Community-based residential treatment services for individuals with co-occurring disorders will continue in one site.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Community residential treatment beds for individuals with co-occurring disorders

Indicator: Continued operation of a residential treatment service for individuals with co-occurring disorders of serious mental illness and substance abuse.

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

PI Data Table A1.16	FY 2006 (Actual)	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target
# Community Residential Dual Diagnosis Beds	12	12	12	12	12 beds

Source(s) of

Information: Program grant

Special

Issues: None

Significance: The need for a specialized integrated treatment program for individuals with both a serious mental illness and a substance abuse problem is supported in the professional literature and a previous study of recidivism at MS State Hospital that indicated that alcohol use is a major factor in individuals returning to the hospital.

Funding: State and Substance Abuse Prevention and Treatment block grant funds

Objective: Community services will be provided for individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Co-occurring disorders - community services availability

Indicator: All 15 CMHCs and the community services division of Mississippi State Hospital will provide services to individuals with co-occurring disorders.

Measure: The number of individuals with co-occurring disorders to be served (6500)

PI Data Table A1.17	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Served–Dual Diagnosis	8965	8914	8598	6500	6500

Source(s) of Information: Adult Services Annual State Plan Survey

Special Issues: The number of individuals served does not necessarily remain constant or increase across years, but rather depends on needs identified at the local level.

Significance: Individuals with co-occurring disorders of serious mental illness and substance abuse require specialized services to reduce their risk of hospitalization or rehospitalization. Each CMHC must provide specialized co-occurring disorders services as part of the requirements for receiving SAPT funding for dual diagnosis services.

Funding: SAPT block grant and state funds

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

The DMH will continue to collect/report information in FY 2010 on the number of individuals served by the community mental health centers and Community Services Divisions of MS State Hospital and East MS State Hospital, who have a co-occurring disorder of substance abuse and mental illness, as defined by the state. “The number (and other demographic information) of individuals receiving “integrated treatment for co-occurring disorders” is an evidence-based practice included in the CMHS Core Performance Indicators-and as noted previously, efforts are continuing to monitor and provide technical assistance to facilitate implementation of guidelines for services for persons with co-occurring disorders. In FY 2009, DMH has continued work to develop the capacity to collect and data on the aggregate total of individuals with co-occurring disorders served in specialized programs. Work is also continuing through its Data Infrastructure Quality Improvement Grant (DIG) project to build the capacity of providers to report the detailed demographic information in URS Table 17 in FY 2010 on services provided for integrated treatment for co-occurring disorders.

Long-Range Planning Committee

The MS State Mental Health Planning and Advisory Council established a Long-Range Planning Committee, which began meeting in June 2005. The work of the committee was suspended because of Hurricane Katrina, but the Council voted to extend the special Long Range Planning Committee, which has continued its work in FY 2009. In August 2009, the Council voted to make the Long Range Planning Committee a Standing Committee.

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

Public Resources

Mental Health Transformation Activities: Consumer and Family Operated Programs and Involving Consumers and Families in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)

Local Advisory Committees

The *MS Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services* require community service providers to have an individual/family advisory committee to advise the governing authority of the local provider entity on matters related to individual/family satisfaction, annual operational plans, performance outcomes, program planning and evaluation, quality assurance/improvement, type and amount of services needed and other issues the advisory committee chooses to address. The committees must include family members and individuals served by the provider, as well as other interested individuals, with representation commensurate with the major services provided by the organization (e.g., mental health services, substance abuse services, visits). Compliance with this requirement continues to be monitored by DMH staff on certification/site visits. As part of a comprehensive review of *DMH Minimum Standards*, in FY 2008, the new Division of Family and Consumer Affairs in the DMH Bureau of Community Services undertook a review of the role of consumers and family members on local advisory councils in Mississippi and in other states and subsequently initiated activities in FY 2009 to improve the effectiveness of the councils based on the review, the Division has proposed changes to the Mississippi Department of Mental Health Minimum Standards for Community Mental Services that, if enacted, will provide more specific guidance regarding the purpose and structure of local advisory councils. The Division has also 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 in FY 2010.

Division of Consumer and Family Affairs

In FY 2007, DMH employed consumers to work part-time in the state office to assist with the peer review process and consumer educational events, as well as to facilitate planning and development of a peer specialist program and employment opportunities. In FY 2008, the DMH established the Division of Family and Consumer Affairs in the Bureau of Community Services, which assumed these responsibilities, as well as oversight of family education programs and drop-in center services. Operational objectives of the division include:

- To ensure that individuals and families are the driving force for improvements in the publicly funded mental health system;
- To help individuals and their families participate in decision-making at all levels of the public mental health system; and,
- To promote the empowerment of individuals and families with mental health needs through education, support and access to mental health services.

In April, 2008, the Division of Family and Consumer Affairs convened a preliminary workgroup of consumer, family and service provider representatives to begin work to general additional input for further development of the goals and objectives of the new division. By consensus, the preliminary

workgroup generated the following suggestions that continue to guide the work of the division:

- Ongoing education of stakeholders, including leadership at the local and state levels, about the importance of consumer and family involvement in services, what that involvement should include;
- Ongoing outreach to build capacity of consumer and family education programs;
- Refinement and education about the role of local advisory councils; and,
- Continued evaluation and refinement of the peer review process.
- Improving coordination of activities designed to increase consumer and family inclusion.

Beginning in FY 2009 and in FY 2010, the Division of Consumer and Family Affairs will continue to develop strategies to facilitate a recovery-oriented mental health system. Activities currently being considered include development of an education and information campaign focused on disseminating information about recovery and empowerment and identification of possible avenues at the state and local level for further promoting recovery-oriented systems change, e.g., through existing advisory councils, committees and task forces. Additionally, the Division will continue to examine strategies that have been successful in other states in promoting recovery and consumer empowerment.

Development of Peer Specialist Services

DMH has received technical assistance on planning for development of peer specialist services in the state (based on Georgia's model. A peer specialist training session in the fall of 2006 involved individuals receiving services, family members, and service providers in training regarding the peer specialist program and the recovery model. In FY 2008, one of the consumers employed by the DMH in the Division of Consumer and Family Affairs completed the one-week Certified Peer Specialist Training in Kansas. In March, 2008, staff from the Division of Consumer and Family Affairs, as well as local provider and NAMI-MS representatives visited peer support programs in Georgia and received technical assistance on program development from certified peer specialists, Medicaid representatives, and Georgia Department of Mental Health staff. Activities to develop peer specialist services continued in FY 2009. In May 2009, the first group of 16 interested consumers received training in the provision of peer specialist services, based on the Georgia model, and a workshop for providers interested in peer specialist services was provided as part of the 2009 Mental Health Community Conference. The Division of Family and Consumer Affairs plans to continue activities to advance the development of peer specialist services in Mississippi, focusing on the provision of education to service providers about the definition and role of peer specialist services in a recovery-oriented system. The Bureau of Community Services will also continue efforts to obtain funding support to provide peer specialist services.

Development of Statewide Consumer Coalition

In FY 2010, the Division of Consumer and Family Affairs and the Division of Community Services plan to continue to facilitate development of an independent statewide consumer coalition. Discussions with interested stakeholders about the potential to develop an independent consumer coalition were held in conjunction with the May 2009 Community Mental Health Conference and facilitated by the National Consumer Empowerment Center. In FY 2010, the Division of Family and Consumer Affairs plans to identify consumers interested in assuming leadership roles in developing a statewide consumer coalition and to seek technical assistance to guide the leadership group on steps that would be necessary to move forward in forming and supporting a coalition, possibly through holding a retreat of identified consumer

leaders to discuss forming and supporting a coalition.

Protection and Advocacy

Disability Rights Mississippi is a private, nonprofit corporation established to protect and advocate for the rights of individuals with disabilities through negotiation, legal, and administrative remedies. Disability Rights Mississippi is independent of any agency, organization or governmental unit providing treatment, services, or habilitation to individuals with disabilities. The staff is also responsible for providing public information concerning the rights of individuals with mental illness and developmental disabilities and will assist professional and citizen groups by providing workshops on the rights of individuals with disabilities, including mental illness. A Board of Directors governs the agency. Two recipients of mental health services, who also serve on the Mississippi State Mental Health Planning and Advisory Council, are on the Advisory Council of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) component of Disability Rights Mississippi.

The purpose of Mental Health Advocacy Services within Disability Rights Mississippi is to protect and advocate for the rights of persons with mental illness. Services provided through the 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 of 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; and identification of problems in the system of service delivery and advocacy to improve the service delivery system. It 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.

Family Education/Support and Consumer Education Support Programs are designed to address three of the major risk factors found to be associated with rehospitalization of individuals at the largest state psychiatric facility: medication non-compliance, current alcohol use (specifically as it affects individuals with mental illness), and family conflict (including education about serious mental illness and skills needed for effective communication among family members and consumers).

The DMH Division of Community Services adopted the Family-to-Family education program, which is conducted by family members, for implementation of the community mental health system's family education component in FY 2000. The Department of Mental Health provides funding to NAMI-MS to make the "Family to Family" education program available to all 15 CMHC regions.

The CMHCs are asked to provide support to NAMI-MS in implementing the family education/support program, through such activities as identifying potential participants, providing meeting space if needed, and/or helping to develop a media campaign to advertise the availability of the program. Under current minimum standards, DMH staff monitor local programs for increased documentation of the types of support provided to family education programs. This requirement was added to help increase the availability and uniformity of family education/support programs across the mental health regions in the state. As of April 2009, the family education program was made available by NAMI-MS to 8 of the 15 CMHC regions across the state. A total of two Family to Family classes had been conducted in two regions (Regions 2 and 9). Additionally, 199 meetings of support groups were held in Regions 2, 3, 4, 6,

9, 10, 13, 14 and 15; 90 groups met, some weekly, some twice a month and others monthly. The NAMI Basics classes (formerly the Parent to Parent classes) were conducted in Regions 11 and 15.

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Availability of family education program

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

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

Source(s) of

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

Special

Issues: As described in the Performance Indicator table that follows, currently, the MS DMH supports NAMI-MS in the provision of the Family to Family program, which reports the number of educational contacts made through that program. “Family psychosocial education” is an evidence-based practice included in the CMHS National Outcome Measures, the proposed definition of which is similar to the components used in the Family to Family Program. In accordance with current CMHS Reporting Guidelines for Evidence-based Practices (URS Table 17), DMH anticipates reporting data for the NAMI Family-to-Family program for FY 2010. DMH will continue to monitor availability of additional information on the effectiveness of the Family to Family program from ongoing research activities. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to address the issue of data collection for family psychoeducation. DMH is continuing work to develop capacity for collection of information for the National Outcome Indicators on evidence-based practices, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project.

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

Significance: The “Family to Family” education program enables family members to become

educated about their family member’s mental illness and facilitates the development of coping skills and support groups.

Action Plan: The NAMI Family to Family program services will continue to be made available to the families of individuals served by the 15 CMHCs, and the Division of Consumer and Family Affairs will facilitate the provision of written material for community mental health centers to provide to consumers and/or family members regarding recovery that will address the availability of NAMI family education and support programs.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 Target
Performance Indicator					
Percentage of persons receiving Family Psychoeducation Services*	Not reported as percentage of persons served in FY 2006	.25%	.12%	.15%	.14%
Numerator: Number receiving Family Psycho education Services*	93 Baseline*	120	64*	65*	70
Denominator: Number of adults with SMI served (community services)		48,493	52,312	42,000	49,000

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

Provider Education

In FY 2003, NAMI-MS initiated the NAMI Provider Education Program in Mississippi. This is a 30-hour course in mental illness education and consumer/provider/family collaboration skills for line staff at public mental health agencies. The five-member training groups include two consumers, two family members and a mental health professional who is also a family member or consumer. As of April 2009, the NAMI Provider to Provider program had been offered at CMRC; 18 providers were trained during the four-day course.

Consumer Education/Support Programs

The Mississippi Leadership Academy (MLA) resulted from a federally funded grant designed to enhance leadership and communication skills of persons with a serious mental illness. Since it was first instituted in Idaho in the early 1990’s, over 20 states have become sponsors, with West Virginia having

replicated the leadership academy model. The coordinator of MLA has received technical assistance from educators from the CONTAC technical assistance center in West Virginia to tailor the academy to meet the needs of Mississippians. The MLA is designed to be offered twice a year; its student body consists of people who are recovering from serious mental illness and who aspire to assume leadership roles in the mental health community, as well as in the community at large. Each class includes approximately 20 graduates. Persons who have participated in Peer-to-Peer training, BRIDGES training or who are interested in increasing their leadership skills will continue to be provided an opportunity to participate in the Academy, as resources are available. As of April 2009, consumer education training programs were made available to all 15 CMHC regions. NAMI-MS offered its Peer to Peer education program, providing five classes in Regions 6 and 10 and at MS State Hospital and Central MS Residential Center; 34 individuals attended these sessions. As a result of the skills individuals learn in the Peer to Peer classes, NAMI-MS has many consumers who now teach the course throughout the state. Others have represented NAMI Mississippi at the NAMI National Convention, held in various cities across years. Peer to Peer graduates also serve NAMI-MS statewide by presenting their personal stories about living with a mental illness as by serving as support group facilitators.

The Mississippi Leadership Academy (MLA) has conducted two training sessions thus far this year, producing a total of 31 graduates (18 in the December 2008 class and 13 in the May 2009 class). The Director of the MLA has maintained contact with all graduates through a newsletter and personal correspondence. Many of them report their leadership involvement with mental health training programs throughout the state (NAMI Peer to Peer and In Your Own Voice; State Mental Health Planning and Advisory Council; Consumer Coalition conferences; peer reviews; and, peer advocacy) and other roles in their communities. At least 14 of the graduates have assumed lead roles on the MLA planning team. Five graduates are advisory board members at local CMHCs, with others expected to assume similar roles during this fiscal year. The Director of the MLA continues to strengthen peer reviews, peer counseling and provider education. The 2009 curriculum promotes active consumer advocacy with regard to law enforcement education personnel and crisis intervention. Most students continue to be referred to the MLA by the regional CMHCs and the state NAMI office; however, a few referrals have come from private practitioners. The Director of the MLA is establishing liaison with the Veterans Administration to provide outreach to more potential MLA students from that arena. The Mississippi Leadership Academy distributed its first newsletter in December 2008. The Division of Consumer and Family Affairs is working with the state Information Technology Services (ITS) agency to enhance the website.

A significant step in converting the MLA to a consumer-led program occurred in February 2009, when the MLA Board, consisting of 14 MLA graduates, was established. The Director of MLA is a consultant to this consumer-led board, which plans to assume total responsibility for teaching the MLA curriculum by December 2010. Board members will teach at least five of the MLA lessons during the September 2009 class. Board members are actively planning for that class and identifying potential students to the director. The Board will meet at least three times prior to the September 2009 class to refine the curriculum and to plan for next year's classes. Additionally, CMRC provides illness management and recovery services to individuals they serve, based on SAMHSA Evidence-based Practice (EBP) Toolkit.

Goal: To provide family and consumer education and support services

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of Consumer Education Program training.

Indicator: Information about the Peer to Peer education program offered by NAMI-MS and the Mississippi Leadership Academy (MLA) will be made available to individuals with serious mental illness served through the public community mental health system.

Measure: The number of individuals receiving services through the Peer to Peer program made available by NAMI-MS and who complete the Mississippi Leadership Academy (MLA)

Source(s) of

Information: Consumer education program records; Grant program reports

Special

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

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

The targeted number of individuals to be served through the Illness Management programs (120) was not completely reached in FY 2008 (103 adults received services). This reduced number was due to a change in administrative staff at NAMI-MS (which administers the Peer to Peer program) during that time period, and use of the organization's staff time to initiate the NAMI Connections support program during that year. The number of individuals targeted to participate in the Illness Management programs also reflects a decrease after FY 2008.

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Mental Health Transformation Performance Indicator					
Percentage of persons served who received illness management/recovery services*	Not reported as percentage of number served in FY 2006	.26	.20	.19	.08
Numerator: Number Receiving Illness Management/Recovery Services*	194 Baseline*	127*	103*	80	40
Denominator: Number of persons with SMI served (community services)		48,493	52,312	42,000	49,000

*In accordance with *CMHS Reporting Guidelines for Evidence-based Practices*, it should be noted that numbers reflect individuals served through programs that involve a specific curriculum; programs will include Peer to Peer, MS Leadership Academy and/or BRIDGES (through FY 2008).

Other Educational/Support Opportunities

The conference is attended by consumers of mental health services, mental health professionals, and interested stakeholders. The Mississippi Community Mental Health Conference, with over 1200 registrants, was held May 28-29, 2009, at the Jackson Convention Center.

DMH will continue to partner with the Mississippi Department of Health and conducted a Health Fair at the individual conferences. The Department of Mental Health, through the Mental Health Association of the Capital Area, has implemented a system to provided educational materials to consumers and family members. Pamphlets will be provided to participants of the mental health conferences and other education materials will be on display at Mississippi Community Mental Health Conference and pamphlets were provided in the conference packets.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

Brief Name: Availability of consumer educational opportunities

Indicator: Continued availability of funding to support educational opportunities for consumers at the annual Mental Health Community Conference, as well as other local, state or national education/training opportunities.

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

Special

Issues: None

Significance: Continuing support of the Annual Mental Health Community Conference, as well as other local, state or national education/training opportunities, will facilitate or enhance the participation of consumers in opportunities to network with other consumers from various areas of the state who may have similar needs, interests and concerns. Examples of materials for workshop activities at the mental health community conference include journals, self-help books, etc., that participants can use in workshops and take home after the training. The educational materials distributed will focus on recovery and empowerment and will be shared with consumers of mental health services, as well as family members, mental health professionals and other interested stakeholders.

Funding: CMHS block grant

Other Support Groups

NAMI-MS also continues to offer NAMI Connection groups in Jackson (two groups), Meridian, Oxford, Southhaven, Corinth and Vicksburg and hopes to continue expansion of the program to other areas of the state. A NAMI Connections Facilitator training is scheduled to be held in Gulfport at the end of September 2009. NAMI Connection is a recovery support group for adults with mental illness, regardless of their diagnosis. Groups are offered free of charge, meet weekly and are led by trained individuals who are also in recovery. NAMI Connection groups offer a flexible and casual environment without an educational format. NAMI-MS is also planning to hold at least one *In Your Own Voice* training session for presenters in FY 2010.

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

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

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Increase in the percentage of adults with serious mental illness served by the public community mental health system reporting that they had been arrested in one year, but were not rearrested in the next year.

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

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

Special Issues: In addition to the data being based on self-report, the low number of total responses to this survey item (25 in 2008) compared to the number of responses to other items on the survey should be considered in interpreting results of this measure. The low response rate to this survey item may be due to survey instrument design (i.e., the addition of “branching” questions added to the end of the original *MHSIP Consumer Satisfaction* survey instrument to gather information on this NOM), which may be confusing to some respondents, as well as to some individuals’ reluctance to respond to questions about their involvement in the justice system.

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

Action Plan: As described in the State Plan (under Criterion 5), the DMH will continue support of law enforcement training provided by the CMHC and will continue efforts to include more community mental health centers in the training efforts. The DMH also plans to increase its networking efforts with the Department of Public Safety and other law enforcement and/or emergency services entities, and mental health providers to increase outreach for training for law enforcement and other emergency services personnel and to explore additional opportunities to divert and/or decrease involvement of individuals with mental illness in the criminal justice system.

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	58%	76%	52%	64%	64%
Numerator: Number of adult consumers					

arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	15	25	13	18	18
Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)	26	33	25	28	28

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

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

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system.

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

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

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

Special Issues: Administration of a state variation of the *MHSIP Consumer Satisfaction Survey* using a revised methodology to produce statewide results began in FY 2004. With consultation and approval from CMHS, the MHSIP was not administered in 2005 because of a delay in start-up (due to a change in staff working on the project) and state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. DMH has worked with the University of Mississippi Medical Center, Center for Health Informatics and Patient Safety, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* in FY 2006 - FY 2009 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community

mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

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

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

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of Families of adult consumers reporting positively regarding social connectedness	74%	75%	71%	73%	73%
Numerator: Number of adult consumers reporting positively about social connectedness	389	500	447	445	445
Denominator: Total number of adult consumer responses regarding social connectedness	526	667	629	607	607

National Outcome Measure (NOM): Improved Level of Functioning (URS Table 9)

Goal: To increase satisfaction of adults with serious mental illness regarding their functioning

Target: Increase or maintain the percentage of adults with serious mental illness who respond positively about their functioning

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system.

Indicator: Percentage of adults with serious mental illness reporting positively regarding functioning.

Measure: Percentage of adults with serious mental illness who respond to the survey and who respond positively to items about their functioning on the *MHSIP Consumer Satisfaction Survey*.

Sources of Information: Results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH)

Special Issues: Implementing many of the same initiatives aimed at improving outcomes and described in the previous National Outcome Measure on outcomes is projected to also impact individuals' perception of their functioning (described in this National Outcome Measure). These initiatives include activities to provide consumer education and support, to facilitate individuals taking a more active role in their recovery and to disseminate evidence based practices.

Administration of a state variation of the *MHSIP Consumer Satisfaction Survey* using a revised methodology to produce statewide results began in FY 2004. With consultation and approval from CMHS, the MHSIP was not administered in 2005 because of a delay in start-up (due to a change in staff working on the project) and state office administrative limitations, disruptions in typical local service provision and burden on local providers who were managing issues related to Hurricane Katrina response and recovery. Since FY 2007, DMH has continued to work with the University of Mississippi Medical Center, Center for Health Informatics and Patient Safety, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the *MHSIP Consumer Satisfaction Survey* to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 9 submission and are reflected in the performance indicator table. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

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

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

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
% age of Families of adult consumers reporting positively regarding functioning	72%	69%	72%	71%	71%
Numerator: Number of families of adult consumers reporting positively about functioning	376	467	456	433	433
Denominator: Total number of adult consumer responses regarding functioning	524	673	629	609	609

Private Resources

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. The Department of Health, which collects data on private psychiatric facilities it licenses, reported 546 licensed/inpatient beds, with an additional 20 beds held in abeyance by ~~MDOH~~ MSDH in FY 2008 for psychiatric services for adults (excluding DMH hospitals and including 21 beds at University Medical Center). The MS Department of Mental Health does not collect data on inpatient hospitals; that information is maintained by the MS State Department of Health, which licenses those facilities in the private sector.

Goal: Decrease utilization of state inpatient adult psychiatric services

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

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health services

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

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

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

Special Issues: DMH is continuing work on development of the data system to support collection of information for the core indicators on readmissions to state psychiatric inpatient facilities, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project. Data was reported through the Uniform Reporting System (URS) tables for FY 2004 – FY 2008. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other national outcome measures by the end of FY 2010. The current data system does not track individuals across the community mental health and state hospital system; therefore, adults in those two systems, though there is some overlap, are likely to represent two different cohorts, that is, except for receiving a preadmission screening, not all adults served in the hospital system were necessarily also clients of the community mental health system. Also, currently, most admissions to the state hospital system are through order of the Chancery Court system. DMH continued work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 20. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits and to have the capacity to track adults served across state hospital and community mental health center settings. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

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

Action Plan: The state psychiatric hospitals will provide routine reports on the number of readmissions by county to community mental health centers. Other planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will also be continued.

National Outcome Measures: Reduced Utilization of Psychiatric Inpatient Beds

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals	2.95% Baseline*	2.43%		2.40%	3.0%

Mississippi

within 30 days					
Numerator: Number of civil readmissions to any state hospital within 30 days	99	84	134	82	106
Denominator: Total number of civil discharges in the year	3,355	3457	3845	3400	3552
2. Decreased Rate of Civil Readmissions at to state hospitals within 180 days	13.8%**	12.79%	17.3%	12.75	14.7%
Numerator: Number of civil readmissions to any state hospital within 180 days	464	442	665	434	524
Denominator: Total number of civil discharges in the year	3,355	3457	3845	3400	3552

** Correction to FY 2006 data.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	29%	29%	29%	29%	
Numerator	2	2	2	2	
Denominator	7	7	7	7	

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

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

Population: Adults with serious mental illness

Criterion: Comprehensive Community-Based Mental Health Service System

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

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

Sources of Implementation: Family to Family education program facilitators' and consumer education program (NAMI Peer to Peer and Mississippi Leadership Academy) records (grant program records)

Special Issues: The pace (and scope) of progress to facilitate dissemination of additional evidence-based practices (integrated treatment for individuals with co-occurring disorders and assertive community treatment) are likely to be impacted by the availability of funding resources.

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

Action Plan: Objectives to maintain EBPs (family psychoeducation and illness self management) and activities to promote the dissemination of additional evidence-based practices (integrated treatment for co-occurring disorders and ACT) described in other sections in the State Plan will be implemented.

Criterion 2: Mental Health System Data and Epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1) (Criterion 1, previous section.)

Prevalence Estimates

Prior to the needs assessment process begun as part of the initial development of the state plan under P.L. 99-660, the state initially applied national prevalence estimates to state population data to derive a broad estimate of need for mental health services among adults. Since current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating incidence and prevalence of serious mental illness among adults, in this year's (FY 2010) State Plan, Mississippi will utilize the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the (national) Center for Mental Health Services in the June 24, 1999, issue of the Federal Register. Estimates in the FY 2010 State Plan are updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state, 2007, prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). As noted in the estimation methodology in the Federal Register, at this time, "...technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence." The publication also indicated that in the future, "incidence and prevalence data will be collected."

The estimated number of adults in Mississippi, ages 18 years and above is 2,155,638 based on U.S. Census 2008 population estimates. According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 116,414 in 2008. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in

1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the “12-month prevalence is estimated nationally to be 5.4 percent...” As stated in the publication, these estimates are based on noninstitutionalized individuals living in the community. Also, as pointed out in the discussion of the federal estimation methodology, “only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time.” The definition of serious mental illness among adults in Mississippi, described under this criterion, falls within the federal definition.

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

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

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Prevalence estimate methodology

Indicator: Utilization of revised estimated prevalence ranges of serious mental illness among adults in the FY 2010 State Plan (as described above), based on the final estimation methodology for adults with serious mental illness published in the June 24, 1999 Federal Register.

Measure: Inclusion of prevalence estimates derived using federal methodology in the FY 2010 Plan.

Source of

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

Special

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

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

Funding: Federal and state funds

State-level Estimates of Prevalence of Depression and Anxiety

As described under Criterion #5 under Information Management, in FY 2005 the DMH began collaborating with the Mississippi Department of Health (DOH), which applied to and received funding from the Centers for Disease Control and Prevention (CDC) to collect state-specific information about

depression and anxiety in calendar year 2006 as an additional optional data collection module, administered as part of an existing population behavioral health status survey, the Behavioral Risk Surveillance System (BRFSS). This population-based telephone survey (of adults) is administered annually by the DOH and collects data in response to core health-related questions, which is reported to the federal Centers for Disease Control (CDC). In FY 2006, the DMH also collaborated with the DOH in development of an additional funding proposal submitted by DOH to the CDC for implementation of another optional module to collect state-specific data on serious psychological distress and stigma in calendar year 2007. Data was completed during calendar year 2007. DMH applied for and received an Administrative Supplement to its Mental Health Data Infrastructure Grant (DIG) to support this collaborative work with the DOH to collect state-specific mental health prevalence estimates for adults in 2006 and 2007. Additionally, the Mississippi Department of Health included the depression and anxiety module in the BRFSS in 2008.

Quantitative Targets: Number of Individuals to be Served

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

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

Population: Adults with serious mental illness

Criterion: Mental Health System Data Epidemiology

Brief Name: Total served in public community mental health system

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

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

Special Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. Data was collected and reported through the Uniform Reporting System (URS) tables on persons served in the public mental health system age 18 and older by gender, race/ethnicity and includes data from the four state-operated inpatient psychiatric units for adults, as well as the DMH-funded community mental health service system. At this point, combined data (above) from the inpatient units and the community mental health programs may include duplicated counts. Also, two of the state-operated psychiatric hospitals provide only acute (short-term) psychiatric inpatient services; the other two hospitals provide both acute and continued (long-term) services. DMH has continued work in FY 2009 on developing the capacity for collection of data for the National Outcome Measure on access to services, including addressing duplication of data across community and hospital systems and other issues, with support from the CMHS Data Infrastructure Grant (DIG).

DMH has continued work in FY 2009 on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Current plans call for reporting of unduplicated data by the end of 2010. As this system continues to be implemented within the FY 2009-2010 time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed. DMH continued work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 2. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure Quality Improvement grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions and to address other data integrity issues also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project in FY 2010 to enable reporting to the CDR by all community providers certified and/or funded by DMH. It is anticipated that the transition from aggregate reporting to reports generated through the CDR may result in adjustments to baseline data, therefore, trends will continue to be tracked to better inform target setting in subsequent Plan years.

Significance: This objective provides an estimate of the service capacity of the public mental health system to provide services to adults with mental illness in FY 2010.

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Performance Indicator					
Total persons 18+ years served in public mental health system*	61,230* Baseline	61,570	65,145	61,230	62,000

*Includes adults with any mental illness (not just SMI) served in state inpatient units and public community mental health programs funded by DMH. Totals to date do not represent unduplicated counts across programs reporting; therefore, baseline data are projected as targets through FY 2008, as duplication in reporting is addressed in ongoing data infrastructure development activities; downward adjustments are anticipated. ** FY 2008 preliminary results were also reported in the FY 2008 URS Table 2A and 2B submission; results and the target for FY 2008 were modified after review/edits by the National Research Institute (NRI) and the MS Department of Mental Health

Target or Priority Population to be Served Under the State Plan

Definitions - Adults with Serious Mental Illness

Note: As described in the Children's Services Plans and in the current Mississippi Division of Medicaid Community Mental Health Manual since FY 2003, the upper age limit in the definition for children with serious emotional disturbances has been extended to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. This is a difference from the federal definition for children, which defines children as being up to 18 years. The change in Mississippi's definition has been made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. (Totals from data in the NOM (URS Tables 2A and 2B) that follow, however, reflect only adults 18 years and above served; detailed data from URS Tables 2A and 2B indicate that 3836 youth/young adults in the 18-20 year age range were served in FY 2008). An adult with a serious mental illness is defined as any individual, age 18 or older, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. It should be noted in the following objective that the number of adults targeted to be served includes only adults with serious mental illness served through the public community mental health system, which is a subset of the number of adults with any mental illness accessing services in the public community mental health and inpatient system, reported in the previous NOM (URS Tables 2A and 2B).

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

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

Population: Adults with Serious Mental Illness

Criterion: Mental Health System Data Epidemiology

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

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

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

PI Data Table A2.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Adults with SMI Served	47,955	48,493	52,312	42,000	49,000

Special

Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented within the FY 2009-2010 time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

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

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

Data Management: The management of adult and children's community mental health services data, including work to establish unduplicated counts, is addressed in the data management objective described in this Plan under Criterion #5 that follows.

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

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) will continue to partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) for a statewide Anti-Stigma Campaign "What a Difference a Friend Makes" until October, 2009.

In October 2009, DMH and the statewide Anti-Stigma Committee will launch a campaign specific to Mississippi entitled, "Think Again." The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. It will continue to show young adults how to support their friends who are living with mental health problems. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children's Services and Adult Services State Plans. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign.

DMH is conducting a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi's Anti-Stigma Campaign efforts have joined forces with DMH's Youth Suicide Prevention Campaign, "Shatter the Silence." DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, and the distribution of flyers and brochures on campus.. DMH incorporates the message of supporting your friends, dispelling the stigma associated with mental health problems and youth suicide in all presentations and handouts.

- Goal:** To address the stigma associated with mental illness through a three-year anti-stigma campaign.
- Objective:** To lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the Anti-stigma campaign.
- Population:** Adults and children
- Brief Name:** Anti-Stigma Campaign – Second Year: “What a Difference a Friend Makes”
- Indicator:** To reach 200,000 individuals during FY 2010
- Measure:** Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers. DMH will also track the number of live interviews and presentations.

MH Transformation PI Data Table	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2006 Plan	Not an objective in the FY 2007 Plan	1.3 million reached	200,000	200,000

Source(s) of

Information: Media and educational presentation tracking data maintained by DMH Director of Public Information.

Special

Issues: Activities to plan and kick-off the first year of the three-year anti-stigma campaign began in FY 2007, therefore, the different themes will overlap the fiscal year(s) addressed in the State Plan. The anti-stigma campaign has partnered with DMH’s youth suicide prevention campaign for presentations and information distributed to young adults.

Significance: Although youth and young adults, 18-25 years of age, are almost double that of the general population, young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on. The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness.

Funding: Federal, State and/or local funds

Additional services available through the public community mental health system to prevent or decrease hospitalization and rehospitalization include mental health outreach services, case management, crisis telephone services, transitional residential programs, discharge planning and consultation/education

services.

Criterion 3: Children Services (only in Children’s Plan)

Criterion 4: Targeted Services to Rural and Homeless Populations-

- **Describes States’ outreach to and services for individuals who are homeless**
- **Describes how community-based services will be provided to individuals residing in rural areas**

Mental Health Transformation Activities: Services for Elderly Persons (NRC Goal 4.4)

According to the 2000 U. S. Census, approximately 16% of Mississippians are age 60 and older. Elderly persons (over 60 years old) with serious mental illness comprised approximately 12.2% of adults with serious mental illness served through the public community mental health system in FY 2008, compared to 10.5% in FY 2005, 11% in FY 2003. (Elderly persons with serious mental illness, over 60 years of age who have had or have developed a serious mental illness as defined for adults under Criterion #2).

Local Plans for Services for Elderly Persons

Historically, a task force was established in 1989 to examine more closely the specialized needs of elderly persons with serious mental illness and to develop strategies to meet those needs for integration in the State Plan. Since that time, all 15 CMHCs have developed a local plan for services to elderly persons with serious mental illness utilizing a guide that emphasizes outreach, interagency coordination of services and case management. The Elderly Services Task Force was reconvened in November 2007 and met again in February 2009.

- Goal:** To provide community mental health and other support services for elderly persons with serious mental illness.
- Objective:** To make available a coordinated local plan for providing services to elderly persons with serious mental illness in all CMHC regions.
- Population:** Adults with Serious Mental Illness
- Criterion:** Comprehensive, community-based mental health system
- Brief Name:** Availability of local plans for elderly services
- Indicator:** Availability of a local plan for providing services to elderly persons with serious mental illness.
- Measure:** The number of CMHCs that submit a local plan for providing services to elderly persons with serious mental illness. (Minimum: 15)

PI Data Table A1.6	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 Target
Local Plans for Elderly Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

*Target modified due to Hurricane Katrina.

Source(s) of

Information: Community Mental Health Center Local Plans for Elderly Services

Special

Issues: None

Significance: The plans will indicate the services that are provided for elderly persons with mental illness in each region.

Funding: Medicaid, state, local, Area Agencies on Aging

Elderly Psychosocial Rehabilitation Programs

Elderly psychosocial rehabilitation is defined as a program of structured activities designed to support and enhance the ability of elderly consumers to function at the highest possible level of independence in the most integrated setting appropriate to their needs. Activities of the program target the specific needs and concerns of elderly persons, while aiming to improve skills that promote independence in daily life. Standards for the program emphasize community outreach, specialized staff training and medical monitoring of individuals served in the program. One of the program goals, in addition to providing a daily therapeutic environment that is age-appropriate, is to establish an outreach program that focuses on locating elderly persons in the community who are not involved in this program but who could benefit from attending. Outreach has been implemented by different programs through various means of public awareness, community meetings, and working with other local organizations.

Since FY 2001, the DMH has continued to identify and assist regions in starting elderly psychosocial rehabilitation programs where appropriate populations could benefit from these services. An elderly service program application must be completed by the provider and approved by DMH prior to the program's certification visit. This ensures that prior to an elderly program certification visit, certain elements of the program have already been reviewed and the region has a clear understanding of DMH expectations regarding services. As of April 2009, there were 58 elderly psychosocial rehabilitation programs, including 27 elderly psychosocial programs in CMHCs and 31 elderly psychosocial programs in nursing homes in CMHC Regions 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14 and 15. Given the expansion of elderly psychosocial rehabilitation programs to date, focus of DMH Division of Community Services activities continue to be on monitoring local programs and providing technical assistance, both to existing and new providers of the service. These technical assistance activities are likely to address areas such as: individualizing activities for individuals across age ranges and physical conditions; accessing specialized training from geriatric specialists; tracking community outreach efforts; and providing public education about mental health needs of elderly persons. Part of the FY 2004 CMHS Block Grant increase used to support technical assistance for elderly psychosocial rehabilitation programs made available through model sites operated by Region 15 Warren-Yazoo Mental Health Services and Region 12 Pinebelt Mental Healthcare Resources continued to be available in FY 2008. Staff employed in the programs are encouraged to attend the training prior to employment. The training

is also offered to staff from other elderly psychosocial programs that receive repeat deficiencies during annual site visits. Objectives of the training are to:

- Identify staff roles and responsibilities for the development, growth, and enhancement of the program
- Understand the importance and effectiveness of planning
- Establish a schedule of daily activities to meet the social, emotional, and physical needs of the participants
- Establish a list of helpful resources for securing both individual and group activities appropriate for the program participants
- Understand and identify transportation safety requirements and certifications
- Establish an environment to meet the physical, social, and emotional needs of the participants
- Identify and document effective ways to provide information about the program and outreach to the community
- Understand the delivery and effectiveness of other services, including individual, group, family therapy, case management services, and nursing services
- Understand and document all necessary data as it relates to program

As of April, 2009, the training site in Vicksburg (Region 15) provided training to three people, and the site in Hattiesburg (Region 12) trained one person.

Goal: To facilitate skills training for staff of elderly psychosocial rehabilitation programs.

Objective: To increase the availability of skills training for staff of elderly psychosocial rehabilitation programs.

Population: Adults with serious mental illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Specialized training for elderly services staff

Indicator: Provision of training for additional staff in elderly psychosocial rehabilitation programs.

Measure: The number of community mental health services staff who complete training for elderly psychosocial rehabilitation programs.

Mental Health Transformation PI Data Table C5.3	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Availability of training for staff in elderly psychosocial rehabilitation programs	Part of another objective in FY 2006; Six training sessions were made available through the Region 15 CMHC training site, with 31 participants.	Part of another objective in FY 2007; Region 15 CMHC training site provided training to 37 participants	Training for 33 staff from elderly psychosocial rehabilitation programs was provided	Training for 10 staff from elderly psychosocial rehabilitation programs	Training for 10 staff from elderly psychosocial rehabilitation programs

Source(s) of

Information: Division of Community Services monthly grant report forms

Special

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

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

Funding: CMHS Block Grant, local funds

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

A DMH Division of Community Services staff will continue to serve as a conference committee member for the annual statewide conference, Alzheimer’s Disease and Psychiatric Disorders in the Elderly. Participation on this committee with staff from the DMH Division of Alzheimer’s Disease and Other Dementia will further ensure that topics pertaining to psychiatric issues affecting elderly persons are addressed at the conference, such as depression and other types of mental illnesses.

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

The Department of Mental Health plans to continue support for 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 the amount of federal funds (PATH) available to serve this group would have the greatest impact. The programs that are funded are located in Jackson (MS State Hospital Homeless Program) in Meridian (East MS State Hospital, Community Services Division), and on the Gulf Coast (Mental Health Association of MS, Gulf Coast Women’s Center and Singing Rivers Services). As of April 2009, the PATH-funded programs had served the following: Gulf Coast Women’s Center –35; MSH Community Services –147; Region 14 Singing River Services –21; Mental Health Association of Mississippi –308;and, EMSH Community Services –21 for a total at mid-year of 532 people served thus far in FY 2009.

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

Objective: Continued provision of services for homeless individuals with mental illness and individuals at-risk of homelessness in targeted areas of the state.

Population: Adults with Serious Mental Illness who are homeless/potentially homeless

Criterion: Targeted services to rural and homeless populations

Brief Name: Services individuals with serious mental illness who are homeless

Indicator: Specialized services will continue to be available for homeless individuals with mental

illness in targeted areas of the state

Measure: The number of persons with serious mental illness served through specialized programs for homeless persons. (900)

PI Data Table A4.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Served– Specialized Homeless	1,292	931	913	600	900

Source(s) of

Information: Adult Services State Plan Survey; PATH Grant Annual Report.

Special

Issues: The number served in previous years included those enrolled in the PATH program and others who had contact and were provided some assistance, but not enrolled. The results of a needs assessment changed the areas of the state targeted to continue to receive PATH funding for provision of services to individuals with serious mental illness who are homeless. Data will continue to be collected since this reconfiguration of programs.

Significance: Specialized outreach and services are needed to identify and address the needs of individuals who are homeless and who also have a serious mental illness, which are often unique and complex.

Funding: PATH (if available), local, and state funds

The DMH Division of Community Services staff member, who oversees the administration of the PATH grant program in MS, served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area. In FY 2009, DMH staff also continued to attend meetings of MISSIONLinks, which is an alliance of emergency and transitional shelter operators and mental health service providers, which was created in the spring of 2002 out of the need expressed by Jackson shelter operators for assistance in serving persons with mental illness who are homeless who use their facilities. Spearheaded by the MS State Hospital Community Services Stubbs Homeless Program, the alliance is comprised of about 20 local agencies, shelters, secondary treatment programs, hospitals and mental health programs. The group's mission is "to provide avenues for information sharing, education and support among emergency/transitional shelter staff and mental health services staff, with the goal of facilitating timely and reliable linkage of mental health services for individuals with mental illness who are homeless."

Additionally, the Division of Community Services staff member working on housing issues for individuals with serious mental illness who are not necessarily homeless, also attends meetings of the Partners to End Homelessness to facilitate coordination of planning. The Partners to End Homelessness (Partners), a group of local service providers, is a permanent partnership to coordinate services to homeless persons in the City of Jackson and Hinds County. Partners is a community-wide effort involving nonprofit agencies, local government and other providers of services to homeless persons, housing providers, neighborhood groups and homeless or formerly homeless persons. The principal organizations involved include: Stewpot Community Services, the Salvation Army, the Veterans

Administration Homeless Services, Catholic Charities, Inc., the Hinds County Human Resource Agency, Jackson-Hinds Comprehensive Health Center Homeless Clinic, the City of Jackson, the Mental Health Association of the Capital Area, Inc., the MS Department of Mental Health/PATH, the Hinds County Board of Supervisors, the Recovery Lodge, MS State Hospital Community Homeless Services, the Good Samaritan Center, Southern Christian Services/PALS, the Jackson Housing Authority, the Mississippi Regional Housing Authority No. VI, Voice of Calvary Ministries, Habitat for Humanity, Daybreak Shelter, Gateway Rescue Mission, New Hope Foundation, and Victory Community Resource, Inc. The Continuum of Care, which is completed by the Partners to End Homelessness, serves to formalize the working relationships, expand and enhance the type and quantity of services that are available for homeless persons in the local community, and provide a strategy for setting and reaching goals to help homeless persons become self-sufficient. A key aspect of the system is the completion of an annual survey among providers of services for homeless persons to help identify gaps in services.

Membership of the Mississippians United to End Homelessness Coalition is statewide and represent the Multi-County Community Action Agency in Meridian, Recovery House in Columbus, Bolivar County Community Action Program, Inc. in Cleveland, Catholic Charities (Guardian Shelter) in Natchez, the City of Natchez, the U.S. Department of HUD in Jackson, the Institute for Disability Studies at the University of Southern Mississippi in Hattiesburg and in Jackson. The goals of this group are to: serve as the lead entity in ongoing efforts to develop and implement a regional Continuum of Care plan; sponsor technical assistance workshops around the state for prospective organizations interested in applying for federal housing funds; and, facilitate and organize advocacy efforts on behalf of homeless persons, such as testimony before elected officials.

In FY 2008, a DMH Division of Community Services staff member continued to attend meetings of five interagency workgroups that identify and/or address the needs of individuals who are homeless. DMH staff serve on MissionLinks, Partners to End Homelessness, Mississippi United to End Homelessness, and Open Door Homeless Coalition, as well as the Permanent Housing Continuum Committee. A staff member also served as a member of the planning committee for the 2008 federal PATH meeting. As of April 2009, DMH staff had participated in the biannual National PATH Conference in Alexandria, VA, networking with State PATH Contacts from other states, PATH technical assistants and federal administrators of the PATH Program. A DMH staff member served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area. DMH staff members also attended monthly MissionLINKS meetings, a group comprised of area organizations dedicated to persons experiencing homelessness.

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

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Gatekeeper workgroup operation and activities

Indicator: Continued participation by a DMH staff member on interagency workgroups that identify and/or address the needs of individuals who are homeless.

Measure: The number of workgroups addressing homelessness on which DMH staff member(s)

participate (up to three)

Source(s) of

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

Special

Issues:

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

Significance:

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

Funding:

State, and federal funds

Definition of areas of the state considered "rural":

In its continued efforts to assess needs and plan strategies to meet those needs in rural areas, the Department of Mental Health will use the new definition of "rural," based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:

"Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)" are classified as "rural." More specifically, the Census Bureau "delineates UA and UC boundaries to encompass densely settled territory, which consists of:

1. Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
2. Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are "split" between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural."

Outreach and Provision of Services to Individuals Residing in Rural Areas

The problems of service availability and access associated with providing services in rural areas, such as transportation, are addressed through both structural and programmatic characteristics of the public community mental health system, including:

Regionalization of Community Mental Health Services

Mississippi is divided into 15 multi-county regions for the planning and implementation of community mental health services. Community mental health services are provided through comprehensive centers located in each region.

County Mental Health Services/Offices

The comprehensive regional community mental health centers maintain services in each county of the service region to improve accessibility of community mental health services.

Mobile Medication Evaluation/Monitoring

Appropriate staff from comprehensive community mental health centers make trips throughout the regions for monthly medication checks for center clients receiving medication through the community mental health center. The 15 CMHCs will continue to make available medication evaluation/monitoring services to individuals with serious mental illness living in all counties, including those that are rural.

Transportation

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 Department of Mental Health. In FY 2008, 15 CMHCs, the Community Services Divisions of EMSH and MSH, and CMRC reported utilizing center operated van/other vehicles; 11 CMHCs and the Community Services Divisions of EMSH reported making transportation affiliations agreements with other agencies; and 12 CMHCs, the Community Services Divisions of EMSH and MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.).

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

Objective: Transportation services will be made available to facilitate access to mental health services for individuals who lack transportation and live in areas removed from delivery sites.

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Availability of local transportation plans

Indicator: Availability of plans by community mental health centers for outreach, including transportation services.

Measure: The number of CMHCs that have available local plans that address transportation services (minimum, 15)

PI Data Table A4.2	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
Local Plans Addressing Transportation	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

Source(s) of

Information: Community support services plan reviews.

Special

Issues: None

Significance: Transportation assistance is needed by some consumers to have access to the services that are available in their communities and/or region.

Funding: Local, Section 18 contracts, Section 16b2 purchasing, SSBG, state, and local funds

Mississippi Statewide Coordinated Transportation System Project

In FY 2008, the DMH Division of Community Services continued implementation of a Rebalancing Initiative, the Mississippi Statewide Coordinated Transportation System project, which was funded through a Real Choice Systems Change Grant that ended on September 30, 2008. The purpose of this planning grant was to develop a design and implementation plan for a statewide coordinated transportation system that will allow Mississippians with disabilities to access community-based long-term supports anywhere in the State, thereby enabling them to 1) live in the most integrated community setting appropriate to their individual support requirements and preferences; 2) exercise meaningful choices about their environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and 3) obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

The no-cost extension period of the project included the project’s final year from October 1, 2007 through September 30, 2008. The major activities of the project during this period included the following: (1) The Mississippi Transportation Coalition, which includes approximately 40 member organizations and serves as the advisory group to the Mississippi Coordinated Transportation System project, continued to meet monthly to develop a plan for coordinated transportation services in Mississippi. (2) The Coast Transportation Coalition, a sub-group of the Mississippi Transportation Coalition, continued to meet. This group was organized to ensure that the plan for coordinated transportation services developed by the Mississippi Transportation Coalition addresses the service needs of citizens in Hancock County, which was especially hard hit by the effects of Hurricane Katrina. (3)The Coalition developed a general description of a coordinated transportation system for the State, providing an overview of how the system should be organized and the roles of the primary stakeholders. (4) Components of the coordinated transportation system were implemented and tested through the Solutions for Individualized Transportation (SIT) project for their effectiveness and recommended inclusion in the final plan for the coordinated transportation system. This project is funded by the Mississippi Council on Developmental Disabilities and managed by The Arc of Mississippi. (5) Staff of the Mississippi Coordinated Transportation System project wrote a grant, which was funded by the Mississippi Council on Developmental Disabilities, to develop specifications and identify possible funding sources for a transportation call center, to be developed in Vicksburg. The Mississippi

Transportation Coalition, which includes representation from the DMH, continues to meet monthly to address coordinated planning for transportation.

The **Telepsychiatry Project** (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), with plans for expansion to some satellite sites in FY 2010. The project also is designed to provide training to front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing).

Minimum services typically available through satellite offices/services include outpatient, medication evaluation, pre-evaluation screening, and/or case management.

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

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

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

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

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

PI Data Table A4.3	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
% Rural Counties with CMHC Office	95%	95%	95%	95%	95%
Numerator: # of rural counties with CMHC office/services*	20	20	20	20	20
Denominator: # of 100% rural counties in MS	21	21	21	21	21

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

Source(s) of

Information: CMHC reports; 2000 Census information.

Special

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

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

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

Criterion 5: Management Systems-

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan.
- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved (2010).

Financial Resources	Available in FY 2009	Projected for FY 2010
Federal Grants (CMHS, SSBG, SAPT, PATH)	4,606,332	4,606,332
State Funds (grants, Medicaid match)	11,926,444	10,119,433
Healthcare funds (grants, Medicaid match)	3,757,146	3,757,146
Trf. from CMHCs for Medicaid match	7,613,250	9,020,000
Special Funds (EMSH/MSH)	6,683,690	6,683,690
Crisis Center funding (total funding)	21,178,110	21,178,110
Local Taxes*	4,063,836	4,063,836
Local Fees	2,750,000	2,750,000
Federal Medicaid Reimbursements*	63,997,293	66,560,920
Total	126,576,101	128,739,467

*Based on estimated use of funds for adult services of 55% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

Efforts to Increase Funding

Mississippi’s budget process is such that funds the Department of Mental Health requests in the 2009 legislative session, which began in early January and would ordinarily meet for 90 calendar days, would actually be available for the fiscal year beginning July 1, 2009 and ending June 30, 2010. But this year was an unusual year, with a couple of extensions to the regular session and 3 special sessions (the first of which occurred during one of the extensions of the regular session), and it was not until the 2nd special session that DMH received an appropriation. Even then, it was not until June 30 that the appropriation bill for the year that began the very next day was passed by both chambers of the legislature, and not until July 13, 2009, thirteen days after the fiscal year began, that the Governor released the signed appropriation bill.

In its initial budget request, the Department of Mental Health requested an increase of \$63,056,062 in general funds for the year that began July 1, 2009. This requested increase was for all services provided through DMH (mental health services for adults and children, services to persons with intellectual and developmental disabilities, services to persons with Alzheimer’s disease and other dementia, and services to persons with substance abuse diagnoses; inpatient and outpatient). Included in that initial requested increase were: \$24,000,000 to cover all Medicaid match for services provided by the 15 CMHCs (adults and children’s services); \$1,006,678 to replace an anticipated cut in federal SSBG services (which cut did not happen); \$622,395 for group homes to be operated by East Mississippi State Hospital Community Services; \$1,810,671 for group homes to be operated by North Mississippi State Hospital Community Services; and, \$135,000 for additional operating costs at community-based crisis centers. The sum of these requested increases, all of which were for community mental health services, is \$27,574,744, representing 44% of the total requested increase from General funds.

The appropriations process for DMH was complicated by the American Recovery and Reinvestment Act (ARRA, also known as “the stimulus plan”). Uncertainty about the benefits of ARRA meant that the legislature postponed appropriation bills for several state agencies, including the Department of Mental Health. By the time the final appropriation bill for DMH was passed, late on June 30, 2009, state source funds for community mental health services (adults and children) were actually reduced, mostly reflecting the lower state share of Medicaid as a result of ARRA, but also reflecting a greater share of match being paid by the CMHCs.

Considering both adults and children, the total projected funding for FY 2010 (\$206,373,281) is \$3,933,393 greater than funding available for FY 2009 (\$202,439,888). That increase is further broken down as follows:

Reduced state source funds available for state share of Medicaid	\$(3,285,474)
Increased contribution from CMHCs for state share of Medicaid	2,557,727
Increased federal share of Medicaid	4,661,140
Total	\$3,933,393

(55% of each figure is deemed to be for adult services, and 45% is deemed to be for services to children.)

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

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Funding Increase Request

Indicator: The Department of Mental Health will seek additional funds in its FY 2011 budget request for community support services for adults with serious mental illness.

Measure: Inclusion of request for increased state funds to support community mental health services for adults in the FY 2011 DMH Budget Request.

Source(s) of

Information: DMH Budget Request, FY 2011

Special

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

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

Funding: State

Staffing**Human Resources, CMHCs: Available in FY 2009 and Needed in FY 2010**

POSITION	Total Staff	Full Time	Part Time
1. Psychiatrists	32	8	24
2. Other Physicians	11	6	5
3. Psychologists, Ph.D.	16	8	8
4. Staff with Master's Degree or Above in Field of Psychology	88	87	1
5. Other Psychologists	4	4	0
6. Social Worker (MSW, Other Master Degree or Above.	209	204	5
7. Other Social Workers	67	66	1
8. Registered Nurses (AA or Above)	44	39	5
9. Licensed Practical or Vocation Nurses	17	12	5
10. Other Mental Health Professionals (Bachelor Degree or Above)	596	577	19
11. Other Mental Health Workers (Less that Bachelor's Degree)	460	336	124
12. Physical Health Professionals	9	6	3
13. All Other Staff (clerical, maintenance, etc.)	302	240	62
14. Totals	1855	1593	262

Funding for Services for Persons with Co-occurring Disorders

In FY 2009 DMH allocated \$1,154,132 from Substance Abuse Prevention and Treatment (SAPT) Block Grant funding to the 15 CMHCs for services to individuals with co-occurring disorders of mental illness and substance abuse; of this amount, \$37,000 was allocated to provide training to all 15 CMHCs. Additional training addressing co-occurring disorders was provided at the 2nd Annual Mississippi School for Addiction Professionals. MSH Division of Community Services was also allocated funding to continue operation of a community-based residential treatment program for individuals with a dual diagnosis.

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

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

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

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

PI Data Table A5.1	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Projected	FY 2009 Target
Funding for Dual Diagnosis Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

Special

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

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

Funding: SAPT block grant funds

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

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

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

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

Source(s) of

Information: Program grant reports

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

Funding: SAPT block grant funds

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

Training of Mental Health Service Providers

The Department of Mental Health has continued to make available case management orientation training for staff hired as case managers in the public community mental health system. As of April 2009, DMH had held four case management orientation sessions, and 106 case managers had been trained. In FY 2008 and FY 2009, training in person-centered planning was incorporated into the case management orientation program.

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Case manager orientation program availability

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

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

PI Data Table A5.2	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Case Management Training Sessions	8;212 case managers trained	8; 219 trained	8; 258 case managers trained	8	8

Source(s) of Information: DMH Training Records

Special Issues: None

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

Funding: State funds

Mental Health Therapist Certification and Licensure Program

The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master's level or above mental health staff members who employed within Mississippi's state mental health system and ~~are~~ who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist curricula was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 contact hours of mental health-related training over a two-year period in order to meet biennial renewal requirements.

Mental Health Administrator Licensure Program

The Mental Health Administrator program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master's level or above individuals who hold positions as the top-level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Program Participants are required to successfully complete the Mississippi Certified Public Manager program and a series of written examinations based on Mississippi rules/regulations/standards. After these requirements have been met, Program Participants are issued licensure as Mental Health Administrators. Once licensed, each individual is expected to accrue at least 40 contact hours continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor's level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, a number of changes were made:

- In an effort to make information and application materials more readily available and to control printing and mailing costs, PLACE staff began converting credentialing information booklets

and application forms to a web-based format. Therefore, PLACE staff will no longer track how many application booklets are mailed out.

- In an effort to control travel costs for program participants and DMH staff, PLACE staff converted the previously required three Mental Health workshops and exams into one study guide and one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. In the future, the study guide will be available online.
- In an effort to control travel costs and promote flexibility for administrators, PLACE staff changed the training requirement for the Mental Health Administrator program from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- In an effort to control travel costs for program participants and DMH staff, PLACE staff changed the training requirement for the Case Management program from three workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.
- In an effort to reduce duplication of information and effort, the reporting of continuing education hours is no longer required when an individual applies to move up from provisional certification to either full certification or licensure. Reporting CEs is now only required upon renewal.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Mental Health Administrator Program and the Case Management Certification Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report contact hours of ongoing in-service/training when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of the number of individuals in the process of pursuing ongoing in-service/training.

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Number of DMH-certified/credentialed staff

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

Measure: The number of individuals who hold a credential in the Mental Health Therapist program; the number of Program Participants and the number of Licensees in the Mental Health Administrator program; the number of individuals who hold a credential in the Case Management Certification program.

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

Special Issues: None

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

Funding: State funds

The number of individuals who hold a credential in the Mental Health Therapist program, the number of Program Participants in the Mental Health Administrator program, and, the number of individuals who hold a credential in the Case Manager Certification Program in FY 2006 -FY 2008 and projected for FY 2009 – FY 2010 are indicated in the chart that follows:

Credentialing Program	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Target)	FY 2010 (Target)
Mental Health Therapists (all levels)	1,495	1,733	1,959	1,973	2,175
Mental Health Administrators (all levels)	104	121	122	122	125
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	Program implemented on July 1, 2005	–	–	-	
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	76	367	629	607	845

Mental Health Transformation Activity: Workforce Development through Academic Linkages
Academic Linkages at the Local Level continued in FY 2008, with 15 CMHCs and the Community Services Division at East Mississippi State Hospital, Mississippi State Hospital and Central MS reporting linkages with state universities and/or state community colleges, as well as private colleges. Areas of training/disciplines represented included: community counseling, social work, psychology, education, counseling, nursing, interdisciplinary alcohol and drug studies, the Center for Civic Engagement and Social Responsibility program, the Faith to Work Initiative, marriage and family counseling, sociology/criminal justice, school counseling, rehabilitation counseling, family and human development, public policy and administration, family studies, counseling psychology, nurse practitioner program, psychiatry, clinical psychology, industrial counseling and human services.

The Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish a rotation in Region 15 (Warren-Yazoo Mental Health Services). The medical director in Yazoo County is also on the clinical faculty at UMMC, as are several of the psychiatrists and psychologists at MS State Hospital. Additionally, a rotation in outpatient substance abuse treatment has been developed with Region 8 mental health center. The UMMC Department of Psychiatry received a grant from the Delta Health Alliance and began implementing a telepsychiatry service with two sites in the Delta region in FY 2009. They initiated services in early August 2008 for two community mental health centers (in Greenwood and in Clarksdale). In addition, the telepsychiatry service will link with the telepsychiatry unit based at MS State Hospital to provide continuity of care for those individuals admitted to the MS State Hospital from the designated Delta community mental health centers. The Department of Psychiatry will also use the telepsychiatry system to train front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). The telepsychiatry project will receive additional funding from the Delta Health Alliance during the next fiscal year (FY 2010) to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. In addition, the Department of Psychiatry is looking into ways of sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

Training of Pre-evaluation Screening for Civil Commitment

Pre-evaluation screening is a step in the civil commitment process, required by state law to be conducted by the CMHCs. The screening is conducted to collect descriptive information and to determine whether or not further examination is needed; a diagnosis is not made during this screening step. This information is provided to the court to determine whether or not it is appropriate to proceed with the commitment examination, which by statute, is conducted by either two licensed physicians or a licensed physician and a licensed psychologist certified to conduct commitment examinations. This pre-evaluation screening is a component of the process for inpatient and outpatient civil commitments. The DMH requires that all CMHC staff who conduct pre-evaluation screening successfully complete specialized training for certification in this area.

As of April 2009, three pre-evaluation training sessions, in which 52 individuals were trained, had been held. Consumers shared their perspectives of going through the pre-evaluation screening process with CMHC staff in the training. Also, staff from the Mental Health Association of the Capital Area, Inc. and the Mental Health Association of Mississippi participated in the training to enhance their understanding of mental health issues and as part of the DMH Module training. In FY 2010, the DMH plans to continue to work with family members and consumers to involve them in the pre-evaluation screening training and/or provide them with information about the screening and civil commitment process.

Objective: Training for CMHC staff in providing pre-evaluation screening for individuals being considered for civil commitment will be made available.

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Pre-evaluation screener training

Indicator: Availability of training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Minimum Standards.

Measure: The number of training sessions in pre-evaluation screening made available by DMH (minimum of four).

PI Data Table A5.3	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# Pre-evaluation Screening Training Sessions	4	8 sessions; 134 trained	6	4	4

Source(s) of Information: DMH Training Records

Special Issues: None

Significance: The pre-evaluation training is designed to increase uniformity in procedure and to better ensure minimum competence level of staff who conduct screening. This training should enhance the information provided to the court and facilitate communication between mental health providers, consumers and families, and the court system.

Funding: State funds

Training of Emergency Health Workers in the Area of Mental Health

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

Training of Law Enforcement Involved in Emergency Situations

Through planning aimed at improving community-based crisis and emergency services, the need for training of law enforcement was identified as a major need and included in the State Plan. Frequently, law enforcement officers may be among the first emergency personnel on the scene who interact with consumers and families in crisis, and they might also be involved in the civil commitment process. The DMH has an agreement with the MS Department of Public Safety to provide professional mental health staff from the CMHCs to provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. As a result, a curriculum was developed and implemented in 1997 for recruits being trained through the six state law enforcement academies. This curriculum was developed by the Law Enforcement Task Force, made up

of family members, consumers, mental health providers and Department of Public Safety representatives. To also address the training needs of experienced law enforcement officers, the Law Enforcement Task Force developed a curriculum for in-service training, through which law enforcement officers currently in the field can receive continuing education credit, which was implemented in 1998. DMH certified trainers from throughout the state have continued to conduct either the recruit or in-service training. In FY 2008, DMH made funding available to 15 CMHCs to help support provision of law enforcement training; 12 CMHC regions applied for and received funding. As of March 2009, CMHCs reported one session was conducted, with 38 law enforcement officers trained. Additionally, the Warden at the Harrison County jail has made a video on the importance of communication between law enforcement and community mental health staff. The video’s message urges law enforcement professionals to take advantage of law enforcement training provided by community mental health center staff. In FY 2009 and FY 2010, the DMH plans to continue support of law enforcement training and to intensify efforts to include more community mental health centers in the training efforts. The DMH also plans to increase its networking efforts with the Department of Public Safety and other law enforcement and/or emergency services entities to increase outreach for training for law enforcement and other emergency services personnel.

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

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

Brief Name: Law enforcement training availability

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

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

PI Data Table A5.4	FY 2006 (Actual)	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Target	FY 2010 Target
# CMHCs collaborating with DMH	Funding available to 15 CMHC Regions; 12 regions participated; 668 officers trained	15 CMHC Regions; 12 regions participated; 37 sessions provided; 1,072 officers trained	Funding made available to 15 CMHC regions; 12 regions participated; 16 sessions provided; 467 officers trained	15 CMHC Regions	15 CMHC regions

Source(s) of Information: DMH Training Records

Special

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

Significance: The Department of Mental Health continues to support training of law enforcement personnel to develop appropriate responses to emergency situations involving individuals with mental illness, since law enforcement personnel may often be the first professional staff on the scene of an emergency.

Funding: State, local funds

Other Initiatives for Training of Emergency Services Personnel

The DMH reconvened the Law Enforcement Task Force that initially developed the training modules for law enforcement (described above), with the intent to revise the training, if needed, for use with other types of emergency/health personnel. The Law Enforcement Task Force reviewed the Department of Mental Health Minimum Standards that require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH. DMH staff continued to monitor implementation of a standard requiring CMHCs to maintain agreements to provide training to local hospitals, as requested. In FY 2008, DMH began collaboration with the Hinds County Sheriff's Department and the Jackson Police Department to establish a CIT program in the Hinds/Jackson area. A Hinds/Jackson CIT Task Force was established in August 2008. In November, 2008, members of that task force attended a three-day training with the Memphis Police Department CIT through the University of Memphis. Legislation to establish the Hinds/Jackson CIT (H.B. 897) was proposed to the Legislature, but provisions pertaining to CIT in the bill did not pass; however, the Hinds/Jackson CIT Task Force plans to continue to move forward in its work to establish the program. In December 2008, DMH staff addressed the Mississippi Chiefs of Police Conference and the Mississippi Sheriff's Association Conference. These presentations communicated DMH's desire to collaborate with law enforcement offices to provide education and support services for officers intervening with citizens experiencing mental illness crises. In April 2009, DMH applied for funding through SAMHSA to establish mobile crisis response teams in Regions 8, 9 and 15; however, as of early August notification of the grant review results had not been received by DMH.

Note: Additional objectives on training in cultural diversity, family education/support, consumer education/support, and psychosocial rehabilitation programs are described under Criterion 1.

Information Management Systems Development

The Department of Mental Health will continue ongoing efforts to implement a more standardized system of computerized data collection, including data needed for reporting on the National Outcome Measures (NOMS) and data needed for reporting in the Uniform Reporting System tables requested by the federal Center for Mental Health Services (CMHS). The national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the

DMH has applied for and received three Mental Health Data Infrastructure Grants (MH-DIG) from the CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.

As mentioned, the DMH has used the DIG funds to support design, refinement and implementation of reporting systems that will facilitate community service providers' and state psychiatric hospitals' submission of data contained in the URS tables. DMH submitted the following ~~2006 and 2007~~ URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16 (some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, the DMH has continued to use DIG funds to support collection and reporting of consumer satisfaction survey information for adults and families of youth served by the public community mental health system. Consumer satisfaction survey information is also being collected to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2010, efforts will continue to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan-related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers' local systems have been problematic in state-level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH - DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined information that is detailed to the client level from all DMH certified and funded providers. As a result, the DMH now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children's services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser based system for

data entry from these organizations.

The DMH Division of Information Systems and Division of Planning staff will continue to participate in CMHS conference calls and national meetings, held regularly to discuss the development of the URS data tables. DMH staff also will communicate regularly with the the community mental health centers'/other providers' data managers as progress on development of the URS data tables continues. DMH Division of Information Systems and Division of Planning staff will also continue work with programmatic staff at the state level in the Bureau of Mental Health and at the local provider level to coordinate development of state plan reporting, including National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the *Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2008- FY 2010)*, which will enable the Mississippi Department of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts for the Uniform Reporting System measures, including the National Outcome Measures as required for the CMHS Block Grant program, to identify trends in services and outcomes, and increase the involvement of stakeholders in planning. The goals of the proposed project are to: (1) Refine the central data repository for public mental health system data; (2) Refine the process for collection and reporting of information from consumer and family satisfaction surveys; (3) Improve data quality assurance systems; and (4) Increase accessibility and use of URS/NOMs measures and other mental health system data by the Mississippi State Mental Health Planning Council, DMH staff and other stakeholders involved in planning and system improvement activities. Through continued data infrastructure development, quality assurance and technical assistance activities described in this proposal, the integrity and completeness of timely, detailed data to support measures for the Uniform Reporting System (URS) tables, including the National Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well as integration of the measures with other quality assurance information, will facilitate state planning and performance improvements across the system of services and supports for individuals with mental illness and their families.

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

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

Population: Adults with Serious Mental Illness

Criterion: Management Systems

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

Indicators/Strategies:

- A) Work will continue to coordinate the further development and maintenance of uniform data reporting and further development and maintenance of uniform data standards across service providers. Projected activities may include, but are not limited to:
- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the

CMHS Data Infrastructure Grants, including the FY 2008-2010 MH DIG Quality Improvement project;

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

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

- Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs;
- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the FY 2008-2010 MH DIG Quality Improvement project, if funded;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Measure: Progress on tasks specified in the Indicator.

Special

Issues: As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

Significance: Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

Funding: State funds, Federal funds

**Projected FY 2010 CMHS Block Grant Projected Expenditures
by Type of Service for Adults with Serious Mental Illness**

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

**Projected Allocation of FY 2010 CMHS Block Grant
Funds for Adult Services by Region/Provider**

Provider	Projected Allocation
Region One Mental Health Center P.O. Box 1046 Clarksdale, MS 38614 Karen Corley Interim Executive Director	\$99,167.14
Communicare 152 Highway 7 South Oxford, MS 38655 Michael D. Roberts, Ph.D., Executive Director	\$126,368.13
Region III Mental Health Center 2434 S. Eason Boulevard Tupelo, MS 38801 Robert J. Smith, Executive Director	\$114,425.14
Timber Hills Mental Health Services P.O. Box 839 Corinth, MS 38834 Charlie D. Spearman, Sr., Acting Executive Director	\$157,105.14
Delta Community Mental Health Services P.O. Box 5365 Greenville, MS 38704-5365 Doug Cole, Ph.D., Interim Executive Director	\$135,283.13
Life Help P.O. Box 1505 Greenwood, MS 38930 Madolyn Smith, Executive Director	\$160,423.80
Community Counseling Services P.O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director	\$131,170.80
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director	\$132,045.79

Mississippi

Hinds Behavioral Health Services P.O. Box 7777 Jackson, MS 39284 Margaret L. Harris, Director	\$140,758.13
Weems Community Mental Health Center P.O. Box 4378 Meridian, MS 39304 Maurice Kahlmus, Executive Director	\$138,304.13
Southwest Mississippi Mental Health Complex P.O. Box 768 McComb, MS 39649 Steve Ellis, Ph.D. Executive Director	\$134,603.13
Pine Belt Mental Healthcare Resources P.O. Box 1030 Hattiesburg, MS 39401 Jerry Mayo, Executive Director	\$150,979.13
Gulf Coast Mental Health Center 1600 Broad Avenue Gulfport, MS 39501-3603 Jeffrey L. Bennett, Executive Director	\$136,553.13
Singing River Services 3407 Shamrock Court Gautier, MS 39553 Sherman Blackwell III, Executive Director	\$101,572.14
Warren-Yazoo Mental Health Services P.O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director	\$92,885.14
Mental Health Association of the Capital Area, Inc. 407 Briarwood Drive - Suite 208 Jackson, MS 39206 Debbie Holt, Executive Director	\$43,031.00
NAMI-MS 411 Briarwood Drive - Suite 401 Jackson, MS 39206 Wendy Mahoney, Executive Director	\$67,802.00

Mississippi

Mental Health Association of Mississippi
P.O. Box 7329
4803 Harrison Circle
Gulfport, MS 39507
Kay Denault, Executive Director

\$50,349

MS Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
Edwin C. LeGrand III, Executive Director

Funds to support training for
elderly psychosocial rehabilitative programs

\$ 9,000

Funds to support consumer education/training opportunities
at annual state conference, as well as other local, state or
national education/training opportunities

\$51,180.00

Funds to support enhancement of employment opportunities

Amt. included in awards for
Region 5 & 6

Funds to support peer monitoring
(Funds listed under DMH may be granted to local entities
for implementation)

\$21,335.00

\$2,194,341

Total

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

Table C. Mental Health Block Grant Funding for Transformation Activities

Transformation Activity	Column 1	Column 2
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the actual or estimated amount MHBG funding that will be used to support this transformation goal in FY 2009
Goal 1: Americans understand that mental health is essential to overall health.		
Goal 2: Mental health care is consumer and family driven.	X	\$255,376
Goal 3: Disparities in mental health services are eliminated.		
Goal 4: Early mental health screening, assessment, and referral to services are common practice.		
Goal 5: Excellent mental health care is delivered and programs are evaluated.	X	\$16,640
Goal 6: technology is used to access mental health care and information.		

Goal II: Mental health care is consumer and family driven. The Division of Community Services uses CMHS Block Grant funding to support a number of efforts to facilitate a recovery orientation for individuals and service providers, including initiatives such as those provided through the Mental Health Association of the Capital Area, Inc. for prevention and for support of a conference for consumers (\$40,862.00), and peer support (\$46,759.00). CMHS Block Grant funds are also used for education, training and support activities provided by NAMI-MS (\$75,802) and to support two drop-in centers for consumers in the north and south parts of the state (\$91,953.00).

Goal V: Excellent mental health care is delivered and programs are evaluated. The Division of Community Services supports the activities of one full-time and two, part-time peer specialists (\$16,640), which include on-site peer review and monitoring of community-based mental health services (as well as other initiatives related to consumer education and support, Goal II).

Note: Activities addressing other Transformation Goals (e.g., a statewide anti-stigma campaign, Goal I; planning and training in cultural competence, Goal III; planning and training in providing integrated services for persons with co-occurring disorders, Goal IV; and, telehealth initiatives to provide psychiatric services/consultation and training, Goal VI) are supported through other federal and/or state funds.

