

**Part D:**

**Mississippi Department of Mental Health  
FY 2010 State Plan Implementation Report**

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## Report Summary

### 1. Summary of Areas Previously Identified by State as Needing Improvement

#### Children's Services

- 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 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.
- Continued collaboration across the Division of Children and Youth Services, the Bureau of Alcohol and Drug Abuse, and the Division of Community Services for Adults to identify and disseminate best practices and other program improvements addressing youth in need of services for alcohol and/or drug use.
- Continued collaboration with the educational system through MAP Teams, the Interagency System of Care Council, and the State Level Case Review Team. Continued training, technical assistance, and certification of school-based programs offered by local community mental health centers.
- Continued funding and support for two Transitional Outreach Programs that serve youth/young adults, between 16-21 years of age.
- Continue funding and support for five comprehensive crisis intervention programs, as well as five smaller, specialized crisis intervention projects.

## Adult Services

- In FY 2009 the Mississippi Legislature approved the Department of Mental Health Crisis Center Redesign Plan, permitting DMH to pilot the transition of operation of the state-operated crisis center in Grenada to operation as a crisis stabilization unit by Life Help Community Mental Health Center. In FY 2010 DMH sought and received legislative approval to transition the remaining six state-operated crisis centers from operation by the state hospitals to operation by regional community mental health centers. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of the remaining six units. The operation of all seven crisis stabilization units will be based on the redesign piloted in Grenada, which includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services.
- Improving the quality of clubhouse psychosocial rehabilitation services throughout all service regions of the state and expanding the number of ICCD certified clubhouses to a minimum of one in each community mental health region in the state.
- Improving the quality and facilitating further development of psychosocial rehabilitation services for persons who are elderly throughout all service regions in the state, including community-based services and services for individuals in nursing homes.
- Creating and maintaining a more person-directed service system for individuals with serious mental illness by incorporating person-centered philosophy throughout Department of Mental Health. As directed by its governing Board, DMH has been working diligently on an agency-wide Strategic Plan that addresses all areas of service responsibility. A major theme of the plan is to achieve a more person-directed service system, which will be reflected in the DMH standards review and revision process.
- Continuing efforts to support and improve specialized programs for persons with mental illness who are homeless. DMH also applied for and received SOAR technical assistance to work with individuals who are homeless and have mental illness.
- Continuing initiatives to improve evidence-based services by providing training to address the full integration of services for individuals with co-occurring disorders of mental illness and substance abuse disorders. In 2010, DMH received federal Transformation Transfer Initiative funding that will facilitate training on effective assessment and treatment in community mental health regions and state hospitals that have not received the training in the previous year.
- DMH is in the final stages of revising its *Minimum Standards for Community Mental Health Services*. Once approved, DMH will begin training service providers on the revised standards and monitoring of programs will begin in the next calendar year.
- Increasing coordination of transportation services to address the needs and barriers experienced by individuals served in the public community mental health system and

exploring funding opportunities to support piloting of initiatives developed by the Mississippi Coordinated Transportation Coalition. DMH received a TTI grant that will enhance the coordination of transportation services and service providers. DMH will also use grant funds to pay for transportation for individuals with disabilities.

- Establishment of a Housing Task Force and initiation of a statewide strategic planning project to develop additional housing options for persons with serious mental illness.
- Continue working with the Division of Medicaid to develop a proposed State Plan Amendment and/or waiver for submission to the Centers for Medicare and Medicaid Services that, if approved, would facilitate changes in community-based services to further support resilience/recovery.
- Continue collaboration with the University of Mississippi Medical Center's Department of Psychiatry and Human Behavior, which is implementing telehealth pilot programs in the Delta region of the state.

## **2. Most Significant Events that Impacted the State Mental Health System in the Previous Year (from FY 2010 Plan)**

### 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.

The Department of Mental Health continued to address the following legislative initiatives in FY 2010:

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 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.

### **3. Purpose for which the FY 2010 Block Grant Expended – Activities Description**

See Criterion #5 of this Report of the Implementation Report for Children’s Services (p. 124) and Adult Services (p. 209).

**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.**

**Quality Improvement System Development**

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

**Peer Review**

**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:** Children with serious emotional disturbance.

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Implementation of peer review

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

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

**Comparison Narrative:**

In FY 2009, peer monitors for children's services participated in reviews at seven CMHC sites (Regions 1, 8, 10, 12, 13, 14, and 15). Peer reviews involved six peer

reviewers. Of the six reviewers, two were family members, three were professionals and one was a consumer.

As of April, 2010, peer reviewers for adult community mental health services had not participated on site visits due to budgetary restraints. However, the Peer Review Task Force continues to review the effectiveness of the peer review process. In FY 2010, the Peer Review Manual was updated, and is awaiting the DMH Standards revision and approval of selected recovery components to be incorporated into the peer review process. The Recovery/Resiliency Self Assessment was developed and is being reviewed by selected CMHC staff, consumers, family members, and interested stakeholders for feedback. This tool will be incorporated into the DMH Standards across all Bureaus to evaluate CMHCs, State hospitals and non-profit services/programs during the site visit process. The assessment for adult services will be adapted for applicability to children's services and is tentatively scheduled to be implemented with CMHCs in 2011.

**Source(s) of**

**Information:** Peer Monitoring schedules/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 (for adults) and to the certified/funded community mental health children's services providers.

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

**Significance:** The establishment of a peer review/quality assurance evaluation system is a provision of the Mental Health Reform Act of 1997. Results of the peer reviews make available to providers additional information/technical assistance specific to their programs that can be used to improve services. The development of a Recovery Self Assessment tools will allow the Department of Mental Health to assess the Community Mental Health Centers and State hospitals identify-strengths that already exist and acknowledge areas that require enhancement and further development.

**Funding:** CMHS Block Grant Funds

**Was Objective Achieved? Yes**

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**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 and 2010 surveys in an effort to increase the response rate to the voluntary survey in individual regions.

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

**Action Plan:** 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 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Performance Indicator</b>					
% Reporting Positively about Outcomes for Children	66%	65%	69%	67%	68%
Numerator	195 positive responses	198 positive responses	514 positive responses	206 positive responses	369 positive responses
Denominator	296 responses	305 responses	742 responses	309 responses	540 responses

**Overall Results of Satisfaction Survey:**

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

**Satisfaction Survey of Parents/Caregivers: Client Perception of Care**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator					
1. % Reporting Positively about Access	90%	87%	90%	91%	89%
Numerator	264 positive responses	264 positive responses	667 positive responses	279 positive responses	477 positive responses
Denominator	294 responses	303 responses	742 responses	308 responses	535 responses
2. % Reporting Positively about General Satisfaction	89%	88%	87%	89%	88%
Numerator	263 positive responses	266 positive responses	651 positive Responses	275 positive responses	481 positive responses
Denominator	297 responses	303 responses	745 responses	309 responses	542 responses
3. % Reporting Positively about Outcomes for Children	66%	65%	69%	67%	68%
Numerator	195 positive responses	198 positive responses	514 positive responses	206 positive responses	369 positive responses
Denominator	296 responses	305 responses	742 responses	309 responses	540 responses

4. % Reporting on Participation in Treatment Planning for their Children	87%	86%	89%	86%	88%
Numerator	255 positive responses	261 positive responses	662 positive responses	265 positive responses	480 positive responses
Denominator	294 responses	303 responses	741 responses	308 responses	541 responses
5. % Reporting High Cultural Sensitivity of Staff (optional)	95%	95%	94%	95%	94%
Numerator	280 positive responses	290 positive responses	701 positive responses	295 positive responses	510 positive responses
Denominator	295 responses	305 responses	744 responses	309 responses	540 responses

**Was objective achieved?** The percentage of parents/caregivers reporting positively about outcomes (NOM) was 1% higher than targeted for FY 2010 (68%); the percentage reporting positively on participation in treatment planning was also higher than targeted for FY 2010 by 2% (88%). Percentages reporting positively were slightly lower than targeted FY 2010 rates for the access domain (89% versus 91%), for the general satisfaction domain (88% versus 89%) and for the high cultural sensitivity domain (94% versus 95%). Rates for all domains were within 2% (over or under) targeted rates.

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

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

**Population:** Children with serious emotional disturbances

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Constituency Services Call Reports

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

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

**Comparison Narrative:**

In FY 2009, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk". This directory gives service providers access to basic program/ service information for over 2100 programs and support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. Approximately 215 new programs were added and over 600 individual program's information was updated in the reporting period. This process is ongoing. OCS recently contracted with the National Suicide Prevention Lifeline to serve as a network provider. Calls from all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since beginning to take calls in mid December 2008, OCS has received over 2300 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports.

In FY 2010, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS also provides all DMH bureau directors with quarterly informal and formal grievance reports indicating follow up and resolution of all complaints and grievances. OCS continues to update the statewide database used for information and referral. Approximately 60 new programs were added and over 500 individual program's information was updated in the reporting period. This process is ongoing. OCS contracted with the National Suicide Prevention Lifeline in December 2008 to serve as a network provider. Calls from

all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since the beginning of FY 2010, OCS has received 7622 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. In January 2010, OCS contracted and developed the capacity to offer individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. OCS is also able to capture data and analyze trends related to the needs expressed by individuals. Since the inception of the program, there have been 189 messages sent and received, 1618 log-ins to the system and 122 individual user accounts created. Data from this program is included in the quarterly reports.

**Source(s) of**

**Information:** Data provided through the software, as calls to the OCS help line logged into the computer system.

**Special**

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

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

**Funding:** State General Funds

**Was objective achieved?** Yes

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**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**

**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

<b>Mental Health Transformation Indicator: Data Table C1.2</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
Number of suicide awareness, prevention sessions/workshops	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, 6 safeTALK, 5 presentations at workshop/seminars	1 ASIST Training, 4 safeTALK, 4 presentations at workshop/seminars	4 safeTALK; 5 presentations at workshops/Seminars

**Comparison Narrative:**

In FY 2009, DMH staff and other staff from nonprofit service provided one ASIST training to mental health professionals in the Metro Jackson area, six safeTALK trainings to students, faculty, and other support staff including security, dorm assistants, coaches, health center, etc.; and five presentations at workshops/seminars including the MADD Annual Conference, SMHART Annual Conference, CommUNITYcares, JSU Student Leaders and NCADD Recovery Celebration.

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

**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.

**Was objective achieved?** Yes

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**Prevention/Early Identification and Intervention Services**

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

**Objective:** To continue availability of funding for 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 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
Prevention/Early Intervention– Funded Program	3 programs funded; 428 children served	3 programs funded; 1105 children served	3 programs funded	2 programs funded	2 programs funded; 439 children served

**Comparison Narrative:**

In FY 2009, DMH continued to provide funding to three prevention programs. As of January 2009, services funded by DMH at Family Support Center for Metro Jackson were suspended. The Division of Children and Youth Services did not anticipate funding this third program in FY 2010. DMH continued to fund Vicksburg Child Abuse Prevention Center and Vicksburg Family Development Center.

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

**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.

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

**Was objective achieved? Yes**

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**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.

**Comparison Narrative:**

In FY 2009, eight CMHCs and Catholic Charities had 74 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts were provided to eight CMHC regions (4, 6, 8, 9, 10, 12, 14 and 15) to encourage providers to make children's mental health services available to serve children.

In FY 2010, eight CMHCs and Catholic Charities had 81 specialized day treatment programs for children ages 3-5 years. Technical assistance contacts were provided to eight CMHC regions (4, 6, 8, 9, 10, 12, 14 and 15) and Catholic Charities to encourage providers to make children's mental health services available to serve children.

**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

**Was objective achieved?** Yes

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**Diagnosis and Evaluation Services**

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

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

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**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.

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

**School-based Day Treatment** continued to be available in FY 2010, and the Division of Children and Youth Services provided technical assistance to school-based day treatment sites as needed. During FY 2010, CMHCs reported a total of 358 day treatment programs, with 121 center-based programs and 237 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 2010, a total of 27,749 children with serious emotional disturbance were reported as having received outpatient services through the 15 community mental health centers, including individual, group, or family therapy services.

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

**School-Based General Outpatient Services**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Availability of school-based general outpatient services

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

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

PI Data Table C1.6	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
Availability of School-based Outpatient Services (Offered to schools)	Offered by 15 CMHC Regions				

**Comparison Narrative:**

In FY 2009, a total of 26,348 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.

In FY 2010, a total of 27,749 children were reported as having received outpatient services through the 15 community mental health centers (center-based and school-based sites), including individual, group, or family therapy services; CMHCs reported having 645 school-based outpatient therapy sites. (Note: The number of school based sites reported span parts of two school years.)

**Source(s) of**

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

**Special**

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

**Significance:** 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

**Was objective achieved?** Yes

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

**Therapeutic Nursing Services**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Availability of funding for therapeutic nursing services.

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

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

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

**Comparison Narrative:**

In FY 2009, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2009, Region 4 nurses made 16,707 contacts, which included services such as providing education for children/youth with SED, their families and teachers; conducting physical observations and assessments; monitoring medications; and monitoring sleeping habits. Region 8 nurses provided 26,202 contacts, which included nursing assessments, medication monitoring and physical observations for those children receiving outpatient services.

In FY 2010, DMH funded Region 4 CMHC to provide therapeutic nursing services in the schools. In FY 2010, Region 4 nurses made 16,964 contacts, which included services such as providing education for children/youth with SED, their families and teachers; conducting physical observations and assessments; monitoring medications; and monitoring sleeping habits. Region 8 nurses provided 38,816 contacts, which included nursing assessments, medication monitoring and physical observations for those children receiving outpatient services.

**Source(s) of**

**Information:** Therapeutic nursing monthly summary form

**Special**

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

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

assistance with health objectives on treatment plans, etc.

**Funding:** Federal funds

**Was objective achieved?** Yes

### Respite Services

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Respite program funded

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

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

PI Data Table C1.9	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# New Respite Providers Trained	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.	43 respite providers trained by MS FAA; Harden House trained 66 respite providers (of which 47 were new).		52 respite providers trained by MS FAA (of which 20 were new); Harden House trained 25 respite providers (of which 25 were new)
# Respite Providers Available			239	75	MSFAA had 97 available providers; Harden House had

					202 available providers
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**Comparison Narrative:**

In FY 2009, the DMH Division of Children and Youth Services continued to provide funding to Mississippi Families As Allies for Children’s Mental Health, Inc. (MS FAA) for respite services. During the year, MS FAA provided training to 43 respite providers (of which 20 were new providers), and reported serving 140 youth; MS FAA reported 62 total respite providers available statewide. DMH also provided funding to Harden House, which provided respite training to 66 providers (of which 47 were new providers) and reported serving 272 youth in respite services in FY 2009; Harden House reported 177 respite providers available through their program.

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

**Source(s) of Information:** Annual State Plan Survey

**Special Issues:** None

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

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

**Was objective achieved? Yes**

**Housing**

**Community-Based Residential Treatment Services**

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

5.2)

### **Therapeutic Foster Care (TFC) Services**

- Goal:** To further develop the community-based residential mental health treatment components of the Ideal Service System Model for Children with Serious Emotional Disturbance.
- Target:** To continue to provide DMH funding to assist in providing therapeutic foster care homes to serve children/youth with SED.
- Population:** Children with serious emotional disturbance
- Criterion:** Comprehensive, community-based mental health system.
- Indicator:** Number of children receiving therapeutic foster care services through a certified program receiving funding from DMH.
- Measure:** Number of children receiving therapeutic foster care services, based on evidence-based practice, provided with DMH funding support (i.e., through Catholic Charities, Inc.)

### **Comparison Narrative:**

In FY 2009, DMH continued to make funding available to Catholic Charities, Inc to help support 24 licensed therapeutic foster care homes. Catholic Charities provides therapeutic foster care to 17 youth in FY 2009. Additionally, five nonprofit private providers certified but not funded by DMH, provided therapeutic foster care services to a total of 205 youth. Twelve certification, follow up and/or technical assistance visits were made to the six therapeutic foster care providers.

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

### **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: In FY 2010, 233 children/youth with serious emotional disturbance received therapeutic foster care services; of this total, 22 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.

**Funding:** State and local funds, SSBG funds, federal discretionary, and/or other grant funds, as available. Additional funds will continue to be available from private nonprofit contributions and foundations.

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Performance Indicator</b>					
<b>Percentage of children with SED served who received therapeutic foster care services*</b>	.08	.09	.06	.08	.07
Numerator: Number Receiving	24	27*	17	23	22

Therapeutic Foster Care Services*					
Denominator: Number of children with SED served by the state mental health agency (community services)	28,939	29,269	30,199	28,500	31,488

**Was objective completely implemented?** Targeted not achieved. The Department of Mental Health continued to provide funding support to one certified provider of therapeutic foster care services (Catholic Charities), which served 22 youth, instead of the 23 youth targeted. The overall number of children served in the public community mental health system (denominator) also increased; therefore, the percentage served was .01 % less than the percentage targeted (.07% versus .08%). As described previously, the DMH also continued to certify other agencies not funded by DMH to provide therapeutic foster care services; these non- DMH- funded, certified providers served 211 additional youth in FY 2010.

### Therapeutic Group Homes

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Therapeutic group homes funded

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

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

PI Data Table C1.11	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Funded Therapeutic Group Homes	Funding allocated for support of 13 homes, which served 237 children. An	Funding for support of 12 homes was allocated, but one of the homes was	Nine	Nine	Nine

	additional 129 youth served through homes certified, but not funded by DMH.	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			
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### Comparison Narrative:

In FY 2009, DMH continued to make funding available for nine therapeutic group homes. A total of 219 children and youth with serious emotional disturbances were served by therapeutic group homes receiving funding from DMH.

- Hope Haven Crisis Residential Therapeutic Homes, Jackson operated by Catholic Charities (99 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (29 served)
- The ARK, Jackson, dually-certified therapeutic group home (two homes) and community- based residential chemical dependence treatment program, operated by MS Children's Home Society and Family Services Association (served 53)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (served 16)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (served 16)

Also, an additional 257 youth were reported as served through therapeutic group homes certified, but not funded by DMH:

- Therapeutic Group Home (males) operated by Center for Family Life Extension, Inc. (15)
- Fondren Village, Inc. (males) group homes, operated by Fondren Village, Inc. (27)
- Millcreek Therapeutic Group Homes (two homes) operated by Millcreek Rehabilitation Center (37)

- Paul's Home for Children group homes (two homes in Sturgis and in Columbus), operated by Southern Foundation for Homeless Children (41)
- The Taylor House Group Home, (males) , operated by The Taylor House Group Home Inc., Greenville (17)
- Bass Group Home (females), Clarksdale, Gulf Coast Girls (females) Gulfport McCarty House (males) Ellisville, McRae Home (females) Jackson and Pendleton Home (Natchez) operated by United Methodist Ministries for Children and Families-(males and females) (61)
- Savior of Life (females), in Jackson (19)
- Saint Joshua's Therapeutic Group Home (males), in Jackson (13)
- Treasure House, operated by Positive Living, Inc. in Jackson (20)
- PALS Transitional Therapeutic Group Homes (two homes, Jackson) (7)

In FY 2010, DMH continued to make funding available for nine therapeutic group homes. A total of 188 children and youth with serious emotional disturbances were served by therapeutic group homes receiving funding from DMH

- Hope Haven Crisis Residential Therapeutic Homes, Jackson operated by Catholic Charities (89 served).
- Hope Village for Children (four therapeutic group homes) for males and females ages 8-16 years of age (31 served)
- The ARK, Jackson, dually-certified therapeutic group home (two homes) and community- based residential chemical dependence treatment program, operated by MS Children's Home Society and Family Services Association (32 served)
- Rowland Home for Youth (Boys), Grenada, Operated by Southern Christian Services for Children and Youth, Inc. (17 served)
- Harden House, Fulton, operated by Southern Christian Services for Children and Families. (19 served)

Also, an additional 261 youth were reported as served through therapeutic group homes certified, but not funded by DMH:

- Therapeutic Group Home (males) operated by Center for Family Life Extension, Inc. (16)
- Millcreek Therapeutic Group Homes (two homes) operated by Millcreek Rehabilitation Center (43)
- Paul's Home for Children group homes (two homes in Sturgis and in Columbus), operated by Southern Foundation for Homeless Children (38)
- The Taylor House Group Home, (males) , operated by The Taylor House Group Home Inc., Greenville (17)
- Bass Group Home (females), Clarksdale, Gulf Coast Girls (females) Gulfport McCarty House (males) Ellisville, McRae Home (females) Jackson and Pendleton Home (Natchez) operated by United Methodist Ministries for Children and Families-(males and females) (85)
- Savior of Life (females), in Jackson (26)
- Saint Joshua's Therapeutic Group Home (males), in Jackson (6)
- Treasure House, operated by Positive Living, Inc. in Jackson (23)

- PALS Transitional Therapeutic Group Homes (two homes, Jackson) (7)

**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 and FY 2010, 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.

**Was objective achieved?** Yes

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**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 2010 included: federal housing assistance (subsidized housing/rental assistance/Section 8/Shelter Plus Care) through local housing authorities; respite/emergency housing, shelter for victims of domestic violence, shelter for abuse/neglected children, transitional housing, assistance in finding housing, education on renting/purchasing and maintaining a household, winterizing, and housing and child care for single parents. In addition to HUD and local housing authorities, examples of other organizations assisting with housing included: Stewpot Community Services, Shelter for Battered Families/Second Stage, Hinds County Human Resource Agency, Salvation Army, the Good Samaritan, Matt's House, Sims House, Our House Wingard House, PALS, the Initiative Program, Bass Home, LIFT, Inc., American Red Cross, Habitat for Humanity, local apartment owners in various communities, Housing Advisory Council/USM/IDS, local churches, Transitional Outreach Program (TOP) for transition-age youth, the Junior Auxiliary and the Mississippi Department of Human Services.

**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 continued work in FY 2010 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 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 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 two specialized programs serving homeless children/youth with SED, described in separate objectives under Criterion 4 in the State Plan. Gulf Coast Women's Center for Nonviolence provides shelter for children and their mothers who are experiencing violence at home. Through Gulf Coast Mental Health Center, a therapist is available on a 24-hour basis to assess and intervene in all crisis situations that occur at the local shelter. The local shelter services children who have allegedly experienced abuse and/or neglect

DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile in FY 2007 through FY 2010.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
Performance Indicator					
% of youth reported homeless/in shelters	.2%	.25%	.33%	.26%	.49%
Numerator: # youth reported homeless/in shelters by DMH certified/funded providers	63	78	104	80	162
Denominator: # All youth reported with living situations by DMH certified/funded providers, excluding Living Situation Not Available	29,622	31,099	31,754	29,955	32,997

**Was objective achieved?** Target not achieved; however, the action plan was implemented. Both the number of youth reported with living situations and the number of youth reported as homeless/in shelters increased. The number of youth served by Gulf Coast Women's Center increased by 44 from last year, which might account for some of this increase, although the exact reason for the increase is not readily apparent from this data.

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## Services to Special Populations

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

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

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

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

**Criterion:** Comprehensive, community-based mental health system.

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

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

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

### **Comparison Narrative:**

In FY 2009, a Division of Children and Youth Services staff member continued to participate on the Fetal Alcohol Spectrum Disorders (FASD) Task Force, the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-Occurring Disorders Coordinating Committee, and the Underage Drinking Task Force (MAAUD). Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK, Sunflower Landing, and the CART House, which serve youth with co-occurring disorders.

Bureau of Alcohol and staff are members of the FASD Task Force. A Division of Children and Youth staff member provided FASD education at Fairland substance abuse treatment facility, which serves pregnant women and women with children. Division of Children and Youth staff participated in the DMH's Annual School for Addiction Professionals.

In FY 2010, a Division of Children and Youth Services staff member continued to participate on the Fetal Alcohol Spectrum Disorders (FASD) Task Force, the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-Occurring Disorders Coordinating Committee, and the Underage Drinking Task Force (MAAUD). Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK, Sunflower Landing, and the CART House, which serve youth with co-occurring disorders. Bureau of Alcohol and staff are members of the FASD Task Force. A Bureau of Alcohol and Drug Abuse Services staff member provided FASD education at Fairland substance abuse treatment facility, which serves pregnant women and women with children. Division of Children and Youth staff participated in the DMH's Annual School for Addiction Professionals.

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

**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

**Was objective achieved?** Yes

- Goal:** To identify children/youth with Fetal Alcohol Spectrum Disorders (FASD) and identify services to meet individualized needs of these children.
- Objective:** To make available FASD screening assessments through the 15 CMHCs and the MAP Teams to identify children/youth that screen positive for possible FASD and need to receive a diagnostic evaluation to determine if an FASD diagnosis is warranted.
- Population:** Children and youth with serious emotional disturbance or at risk for serious mental illness who are suspected to have an FASD.
- Criterion:** Comprehensive, community-based mental health system.
- Brief Name:** FASD screening availability
- Indicator:** The number of FASD screenings conducted by the CMHC and/or the MAP Team in which community service providers make available FASD screening in accordance with DMH minimum standards or which submit an acceptable Plan of Correction if not in compliance with standards
- Measure:** Count of the number of FASD screenings conducted each year in or through the CMHCs and the MAP Teams.

Data Table	FY 2008 (Estimate)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
FASD screenings conducted	Not an objective in the FY 2008 State Plan, but it is estimated that 1,848 screenings will be conducted	1,231	800	1,471

**Comparison Narrative:**

In FY 2009, the CMHCs screened 1,231 children ages birth to seven to identify those children who needed to be referred to the Child Development Center at UMMC for a full FASD diagnostic evaluation.

In FY 2010, CMHCs screened 1,471 children ages birth to seven to identify those children who needed to be referred to the Child Development Center at

UMMC for a full FASD diagnostic evaluation.

**Source(s) of**

**Information:** DMH Division of Children and Youth Services monthly service report forms and MAP Team referral reports.

**Special**

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

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

**Funding:** Federal, state and/or local funds

**Was objective achieved?** Yes

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

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

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

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

**Comparison Narrative:**

In FY 2009, a designated Children and Youth Services staff member continued to participate on the Co-Occurring Disorders Coordinating Committee. Additionally, the System of Care Project (commUNITY cares), now in its third year of implementation and serving children/youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar Counties, continues to provide workshops specifically addressing co-occurring disorders; topics such as cognitive behavioral therapy techniques, strength-based wraparound approaches, and *The*

*Seven Challenges* program were included. The 2nd Annual Mississippi School for Addiction Professionals held 1/20/09-01/23/09, provided several break out sessions on youth with co-occurring disorders. Additionally, the Annual Lookin' To the Future Conference held in July 2009 provided sessions on youth with co-occurring disorders.

In FY 2010, a designated Children and Youth Services staff member continued to participate on the Co-Occurring Disorders Coordinating Committee. Additionally, the System of Care Project (commUNITYcares), now in its fourth year of implementation and serving children/youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar Counties, continues to provide workshops specifically addressing co-occurring disorders; topics such as cognitive behavioral therapy techniques, strength-based wraparound approaches, and *The Seven Challenges* program were included. The 3rd Annual Mississippi School for Addiction Professionals held in January 2010, provided several break out sessions on youth with co-occurring disorders. Additionally, the Annual Lookin' To the Future Conference held in July 2010 had eight sessions targeted on alcohol and drug abuse in youth including addiction treatment for youth, trends in alcohol/drug use among teens, the psychological dynamics of addiction, effective interventions, scope of practice for addiction counselors, the impact of substance abuse on adolescent's cognitive development, and dangerous drugs in medicine cabinets.

**Source(s) of**

**Information:** Conference program(s)

**Special**

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

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

**Funding:** Federal and state

**Was objective achieved?** Yes

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**Community-based Residential Treatment Programs for adolescents with substance abuse**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Availability of community substance abuse treatment program beds

**Indicator:** Availability of community-based residential treatment program services for adolescents with substance abuse problems provided through sites in FY 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 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Beds Funded Residential Treatment Program	56 beds available; 175 youth served	56 beds available; 146 youth served	137 youth served in 56 beds	56 beds available	56 beds available*; 102 youth served

\*One program, CART HOUSE, operated part of the year.

**Comparison Narrative:**

In FY 2009, the three programs served 137 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in a community based residential treatment. Sunflower Landing served 53 youth (50 of whom had co-occurring disorders); CART House served 35 youth; and, the ARK served 49 youth, 46 of whom had co-occurring disorders).

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

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** Federal funds

**Was objective achieved?** Yes

## **Youth with 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.

In FY 2010, two CMHCs, (in Region 3 and Region 10) provided school-based day treatment programs for children and youth with co-occurring disorders of mental illness and mental retardation.

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

#### **Multicultural Task Force**

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

**Population:** Children with Serious Emotional Disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Multicultural Task Force operation

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

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

#### **Comparison Narrative:**

In FY 2009, the Multicultural Task Force (MCTF) met on November 21, 2008, June 22, 2009, August 17, 2009, September 14, 2009. The task force organized the statewide Day of Diversity held on October 13, 2008; on November 3, 2008, the co-chair of the MCTF presented at the 27<sup>th</sup> Annual MH/MR Joint Conference on cultural competency and disparities. On April 17, 2009, the “Cultural and Linguistic Competency: Keeping It Real” workshop was held. The presenter was Dr. Vivian Jackson with the National Center for Cultural Competency. Approximately, 85 service providers attended the workshop. The annual report of task force activities was made to the Mississippi State Mental Health Planning and Advisory Council on August 17, 2009.

In FY 2010, the Multicultural Task Force had met on November 23, 2009, and April 16, 2010, June, 24, 2010, August 19, 2010. The task force organized the statewide Day of Diversity that was held on October 13, 2009. The annual report to the Planning Council was presented by the Co-Chair of the task force on April

22, 2010. On September 1-2, 2010, several task force members attended the “Building a Community of Diversity: Understanding Cultural Competency workshop”. The workshop was a collaboration between Department of Mental Health, MTOP and commUNITYcares. The presenters were Dr. Ken Martinez, lead for the TA Partnership’s Cultural Competence Action Team and Holiday Simmons, community educator in the Southern Regional Office of Lambda Legal. The co-chair was one of the organizers of the workshop. On September 22, 2010, the co-chair of the Multicultural Task Force presented at the 2010 Rural Behavioral in Glendale, Arizona, with Dr. Vivian Jackson on “Disparities within Disparities: A Look at the 5 A’s Through the Eyes of Person of African Heritage in Rural America”.

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** State funds

**Was objective achieved?** Yes

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**Local Provider Cultural Competence Assessment**

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

**Population:** Children with Serious Emotional Disturbances

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Cultural competency pilot project expansion

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

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

**Comparison Narrative:**

In FY 2009, Region 11 CMHC received their cultural competence assessment results on May 8, 2009. A staff member met with staff from Region 2 CMHC on July 21, 2009, to discuss the cultural competency assessments.

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

**Source(s) of Information:** DMH Activity Reports

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

**Funding:** State and local funds

**Was objective achieved?** Yes

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

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Cultural diversity training

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

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

**Comparison Narrative:**

In FY 2009, 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. The DMH continued to use the National Coalition Building Institute's (NCBI) Prejudice Reduction Training Model. Children/ youth service providers had the opportunity to participate in their local CMHC Day of Diversity activities in Oct. 2008. The 20<sup>th</sup> 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. Three NCBI trainings were conducted at Region 8 (Copiah County, Rankin County and Simpson County) in April 2009. An NCBI training was provided to Region 3 Mental Health Center staff in April 2009. In May 2009, staff conducted a cultural diversity training session at the Consumer Conference. NCBI training was also conducted for MS Families As Allies for Children's Mental Health, Inc. in June 2009. An NCBI training was conducted at Region 1 Mental Health Center in September 2009.

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

The DMH Minimum Standards for Community Mental Health/Mental Retardation Services continued to require that all programs certified by DMH train newly hired staff in cultural diversity/sensitivity within 30 days of hire and annually thereafter. Compliance with standards continues to be monitored on site visits. The DMH Division of Children and Youth Services continued to require additional assurances from providers with which it contracts that training addressing cultural diversity and/or sensitivity will be provided.

**Source(s) of**

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

**Special**

**Issues:** None

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

Minimum Standards.

**Funding:** Local, state, and federal funds

**Was objective achieved?** Yes

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## **Mental Health Transformation Activity: Improving Access to Employment**

### **Rehabilitation and Employment Services**

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

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

Specific examples reported of vocational/employment services accessed for youth by individual children's community mental health service providers in FY 2010 included: job skills training, academic and vocational training, GED programs, summer employment, Job Corps, employment placement, supported employment, transitional services, work ready programs, occupational skills training, TANF work program, and independent living skills 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, Ability Works of Mississippi, Millsaps Career Center, Recruitment/Training Program of Mississippi, Mississippi Department of Transportation, county governments, Youth Challenge Program, MIDD West Industries, PRCC, local nonprofit organizations, and community colleges.

## Substance Abuse Services

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

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

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

In March 2006, BADA was awarded funds by the CSAP for a State Epidemiological Outcomes Workgroup (SEOW). In October 2006 this grant was incorporated into the newly awarded Strategic Prevention Framework State Incentive Grant (SPF SIG) (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](http://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 use prevention**

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

The Bureau of Alcohol and Drug Abuse funded tobacco *use* 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 2011 require all contractors to provide some DMH/BADA approved tobacco use prevention information/education activities. Each mental health region also conducts merchant education in their respected area. Each region is required to provide education to a minimum of 40 merchants.

### **Substance Abuse Services for Adults and Children**

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

**General Outpatient Services:** The DMH Bureau of Alcohol and Drug Abuse continued to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continued to certify 9 free-standing programs which also provided these services. One of the free-standing programs, Metro Counseling Center provides day treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care. In FY 2009, there were 6,184 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 2009, there were 414 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 one adolescent inpatient program, which is the Bradley Sanders Complex, an extension of East MS State Hospital, which served 83 youth in FY 2009.

**Primary Residential Services:** These services are for persons who need intensive residential treatment who are addicted to alcohol and drug problems. Services are easily accessible and responsive to the needs of the individual. In residential treatment, various treatment modalities are available, including individual and group therapy; family therapy; education services; vocational and rehabilitation services; recreational and social services. Adolescents who need primary residential treatment for alcohol and drug problems are provided intensive intervention. Individual, group and family counseling are offered as well as education programs at the appropriate academic levels. Adults and adolescents with a co-occurring disorder of mental illness and substance abuse are also provided treatment in a primary residential setting. These services are provided by 14 community mental health programs, 11 certified free-standing programs and three community-based treatment programs for adolescents programs. In FY 2009, there were 3,890 adults and adolescents who received these services; 137 adolescents were served in the three specialized programs.

**Transitional Residential Services:** These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program before being eligible for admission to a transitional residential program. These services are provided by 9 community mental health centers and 13 certified free-standing programs. In FY 2009, there were 1,172 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 2009, there were 4,339 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 2009, the Office of Constituency Services received and processed 731 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 2009, 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 2009, vocational services were provided to 128 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 2009, 11,419 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 2009, there were 2,191 individuals who were eligible for DUI services and 1,711 inmates at the Mississippi State Penitentiary who were eligible for the residential alcohol and drug abuse treatment program.

### **Private Resources**

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 52 licensed and/or Certificate of Need (CON) approved beds in FY 2009 for adolescents. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

### **Health/Medical and Dental Services**

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

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

hospitals, and Federally Qualified Health Centers.

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

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

with, but not limited to, the local MAP teams, State Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

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

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

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

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

the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

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## Mental Health Case Management Services

### Outreach and Expansion of Case Management Services

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Provision of case management services

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

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

PI Data Table C1.14	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# SED Receiving Case Management*	15,011	14,995	14,666	13,000	15,181

### Comparison Narrative:

In FY 2009, 14,666 children with serious emotional disturbance, including children receiving Medicaid, were reported as having received case management services through the CMHCs. In FY 2009, 300 CMHC case managers provided services to children/youth with SED; 82 of these case managers were reported to also have served adults.

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

**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

**Was objective achieved?** Yes

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

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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.

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**Activities To Reduce Hospitalization**

**Community-Based Emergency Response/Crisis Intervention**

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Comprehensive crisis response models funded

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

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

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

**Comparison Narrative:**

In FY 2009, the DMH continued to fund five comprehensive crisis response programs for youth with SED or behavioral disorders. Catholic Charities (Hope Haven) continued to target Hinds County and the surroundings area. Hope Haven includes five crisis residential beds on a regular basis, with potential capacity of up to seven beds. The second model, operated by Community Counseling Services in Region 7, continued to include a mobile crisis line and mobile crisis team, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. The third model, operated by Pine Belt Mental Healthcare Resources in Region 12, provides community-based crisis response services that are available on a 24-hour basis and an emergency on-call team both during and after work hours. The fourth program, Region 8 Community Mental Health Center, received funding to offer management and psychiatric/therapeutic nursing services to children/youth with SED and their families. These comprehensive crisis response programs continued participation on MAP teams and in other activities described above. A fifth smaller program, Region 4 (Timber Hills Mental Health Services) implemented a mobile crisis response team, consisting of seven, experienced Bachelor's level case manager with knowledge in crisis intervention, one Master's level therapist on call 24 hours a day for all four counties, and three Master's level coordinators on-call 24 hours a day. A mobile crisis team serves all the counties in Region 4, with at least two team members per county.

In FY 2010, the DMH continued to fund five comprehensive crisis response programs for youth with SED or behavioral disorders. Catholic Charities (Hope

Haven) continued to target Hinds County and the surroundings area. Hope Haven includes five crisis residential beds on a regular basis, with potential capacity of up to seven beds. The second model, operated by Community Counseling Services in Region 7, continued to include a mobile crisis line and mobile crisis team, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. The third model, operated by Pine Belt Mental Healthcare Resources in Region 12, provides community-based crisis response services that are available on a 24-hour basis and an emergency on-call team both during and after work hours. The fourth program, Region 8 Community Mental Health Center, received funding to offer management and psychiatric/therapeutic nursing services to children/youth with SED and their families. These comprehensive crisis response programs continued participation on MAP teams and in other activities described above. A fifth smaller program, Region 4 (Timber Hills Mental Health Services) implemented a mobile crisis response team, consisting of one experienced Bachelor's level case manager with knowledge in crisis intervention, six Master's level therapists on call 24 hours a day for all four counties, and two Master's level coordinators on-call 24 hours a day. A mobile crisis team serves all the counties in Region 4, with at least two team members per county.

**Source(s) of**

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

**Special**

**Issues:** None

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

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

**Was objective achieved?** Yes

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**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)

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

**Comparison Narrative:**

In FY 2009, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects. Region 3 CMHC served 227 youth; Region 13 served 301 youth; Region 15 served 45 youth; Gulf Coast Women's Center served 44 youth; and MS Families as Allies for Children Mental Health, Inc. served 283 youth.

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

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** Local, state, Medicaid and CMHS block grant

**Was objective achieved?** Yes

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

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

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

capabilities.

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Family education/support funding

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

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

PI Data Table C1.13	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Family Education Groups	8 family education/support groups were available through MS FAA (Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, and Hancock counties)	89 family education/support groups were available through MS FAA at 14 locations (Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, Marion, Adams, Jackson, Warren, and Hancock counties)		
# Family Workshops/Training Opportunities Provided/Sponsored	MS FAA provided 19 family workshops/training opportunities with 220 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS	MS FAA provided 20 family workshops/training opportunities with 247 participants; five Parent to Parent (NAMI Basis) classes with 40 participants (20 meetings/192 contacts) provided by NAMI-MS	15	15

**Comparison Narrative:**

In FY 2009, DMH continued to make funding available for family education and

family support. In FY 2009, Mississippi Families As Allies for Children's Mental Health, Inc. made available 89 family education/support groups (serving people from Hinds, Rankin, Madison, Yazoo, Desoto, Forrest, Lamar, Jones, Harrison, Marion, Adams, Hancock, Desoto and Jackson counties) and provided 20 family workshops and training opportunities involving 247 participants. NAMI-MS has replaced Visions for Tomorrow and Parent to Parent classes with NAMI-Basics. There were five Parent to Parent (NAMI Basics) classes with 40 participants (20 meetings/192 contacts) and 24 Parent Support Meetings with 152 participants in FY 2009.

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

**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

**Was objective achieved?** Yes

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**Other Activities Leading to Reduction of Hospitalization**

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

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

**Population:** Children with serious emotional disturbances

**Criterion:** Comprehensive, community-based mental health services

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

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

**Sources of**

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

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

**Significance:** 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:** Planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will be continued, as well as initiatives to facilitate the use of evidence-based practices.

## 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 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Performance Indicator</b>					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	1.3%	1.3%	.25	1.2%	.8%
Numerator: Number of civil readmissions to any state hospital within 30 days	5	5	1	4.6	3
Denominator: Total number of civil discharges in the year	384	375	402	390	375
2. Decreased Rate of Civil Readmissions to state hospitals within 180 days	5.99%	5.6%	5.47%	5.9%	5.1%
Numerator: Number of civil readmissions to any state hospital within 180 days	23	21	22	23	19

Denominator: Total number of civil discharges in the year	384	375	402	390	375
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\*\*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.*

**Was objective achieved?** Yes; readmissions within 180 days decreased from FY 2009 to FY 2010. The readmissions within 30 days increased slightly (from 1 to 3) from FY 2009 to FY 2010. The discharges decreased across these two years, which resulted in an increase in the percentage of readmissions within 30 days from FY 2009 to FY 2010; however, the targets for this NOM were met.

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**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 and 2010 surveys in an effort to increase the response rate to the voluntary survey in individual regions.

**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.

<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>					
% age of Families of children/adolescents reporting positively regarding social	83%	85%	87%	84%	85%

connectedness					
Numerator: Number of families of children/adolescents reporting positively about social connectedness	243	259	646	260	459
Denominator: Total number of family responses regarding social connectedness	294	305	741	308	540

Was objective achieved? Yes

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### 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 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 and 2010 surveys in an effort to increase the response rate to the voluntary survey in individual regions.

**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.

<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>					
% age of Families of children/adolescents reporting positively regarding functioning	68%	67%	70%	67%	68%
Numerator: Number of families of children/adolescents reporting positively about functioning	200	203	520	207	366
Denominator: Total number of family responses regarding functioning	296	305	744	309	540

**Was objective achieved?** Yes

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

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

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

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

**Population:** Children with serious emotional disturbances

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

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

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

**Sources of**

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

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

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

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

**Was objective achieved?** Yes

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

## **Total Number of Children with Serious Emotional Disturbance**

### **Prevalence in Mississippi**

**Goal:** To include in the State Plan a current estimate of the incidence and prevalence in the State of serious emotional disturbance among children, in accordance with federal methodology.

**Objective:** To include in the State Plan an estimate of the prevalence of serious emotional disturbance among children in the state.

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Mental Health System Data Epidemiology

**Indicator:** Utilization of revised estimated prevalence ranges of serious emotional disturbance among children and adolescents (9-17 years of age) in the FY 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.

### **Comparison Narrative:**

In the FY 2009 and FY 2010 State Plans, Mississippi utilized the final methodology for estimating prevalence of serious emotional disturbance among children and adolescents, as published by the (national) Center for Mental Health Services (CMHS) in the July 17, 1998, issue of the Federal Register, updating its estimates using data from the 2000 U.S. Census.

Estimates in the FY 2009 and FY 2010 State Plans were updated from Uniform Reporting System (URS) Table 1: Estimated number of children and adolescents, age 9-17, with serious emotional disturbances by state, prepared by the National Association of Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). In the methodology, prevalence estimates were adjusted for socio-economic differences across states.

Given Mississippi's relatively high poverty rate when compared to other states, the estimated prevalence ranges for the state (adjusted for poverty) were on the higher end of the ranges in the 7/17/98 Federal Register. The estimated number of children, ages 9 through 17 years in Mississippi in 2008 is 378,753\* Mississippi remains in the group of states with the highest poverty rate 32.6% ages 5-17 in poverty); therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2009 and were as follows:

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

As pointed out in the methodology, there are limitations to these estimated prevalence ranges, including the “modest” size of the studies from which these estimates were derived; variation in the population, instruments, methodology and diagnostic systems across the studies; inadequate data on which to base estimates of prevalence for children under nine; and, inadequate data from which to determine potential differences related to race or ethnicity or whether or not the youth lived in urban or rural areas. As noted in the discussion of the estimation methodology in the Federal Register, “(t)he group of technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence.” The publication also indicated that “(I)n the future, incidence and prevalence data will be collected.” As explained in the section that follows on the population of children targeted in the FY 2010 Plan, the upper age limit in the definition for children with serious emotional disturbances was extended (beginning in the FY 2003 Plan) to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. The change in Mississippi's definition was made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to the adult system, based on their individual strengths, needs and preferences. Although this constitutes a difference from the federal definition for children with serious emotional disturbance, which defines children as being up to 18 years, it is recognized in the 5/20/93 Federal Register that some states extend this age range as high as to persons less than age 22. In such cases, it was also noted in the Federal Register (5/20/93), that states should provide separate estimates for persons below age 18 and for persons aged 18 to 22. Since Mississippi has extended its age range for children with SED up to age 21 years, and kept its lower age range for adults with serious mental illness at 18 years, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (133,693\*\*), yielding an estimated prevalence of 12,300 in this transition age group.

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

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

**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

**Was objective achieved?** Yes

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**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 and FY 2010 on addressing duplication of data across community and hospital systems and other issues related to developing the capacity for collection of data for the National Outcome Measure on access to services with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. As this system continues to be implemented 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 and FY 2010 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 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator					
Total persons under 18 years served in public mental health system*	30,433*	31,189	31,821	30,000	38,060

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

**Was objective achieved?** Yes

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### Target or Priority Population to be Served Under the State Plan

#### Community-based Services for Youth with Serious Emotional Disturbances

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

- Goal:** To make available a statewide, community-based comprehensive system of services and supports for youth with serious emotional disturbances and their families
- Objective:** To maintain provision of community-based services to children with serious emotional disturbance.
- Population:** Children with serious emotional disturbance
- Criterion:** Mental Health System Data Epidemiology
- Brief Name:** Total served in community mental health services
- Indicator:** Total number of children with serious emotional disturbance served through the public community mental health system.
- Measure:** The count of the total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance (28,500)

PI Data Table C2.1	FY 2007 (Actual)	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# SED Served	28,939	29,269	30, 199	28,500	31,488

**Comparison Narrative:**

In FY 2009, 29,565 children with SED were reported to have been served through the regional community mental health centers, and 634 children with SED were reported to have been served through other nonprofit providers certified and receiving funding from DMH; a total of 30,199 youth with SED were served through the public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.

In FY 2010, 30,767 children with SED were reported to have been served through the regional community mental health centers, and 721 children with SED were reported to have been served through other nonprofit providers certified and received funding from DMH; a total of 31,488 youth with SED were served through the public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.

**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.

**Was objective achieved?** Yes

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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)**

**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 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Individuals reached by Anti-stigma campaign	Not an objective in the FY 2007 Plan	1.3 million reached	900,000 (approximately)	200,000	1.5 million

### Comparison Narrative:

In FY 2009, DMH continued to expand its statewide anti-stigma campaign. The anti-stigma committee met four times throughout the year to discuss statewide efforts and to plan for the new anti-stigma campaign which was launched in October 2009. Since Oct. 1, 2008 more than 15,000 anti-stigma brochures were distributed. A majority of these brochures were distributed at Miss. colleges and high schools. Beginning in 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. Since October 1, 2008, DMH made more than 75 presentations on the two topics. Speaking engagements included high schools, middle schools, colleges, school counselors and nurses, and teachers and principals. Displays were set up at conferences statewide including the Governor's Obesity Conference, Jackson State University Mind and Body Fair, Looking to the Future Conference, and the Suicide Prevention Workshop. In January 2009, more than 1,500 students and teachers in Newton County participated in the 3<sup>rd</sup> Annual Mental Health Awareness Day at Central Miss. Residential Ctr. The day focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems. In May 2009, DMH partnered with MSH and the Rankin County Chamber of Commerce to host the event, "Games Your Children Play" in Rankin county. The conference targeted parents, teachers, caregivers, etc. and discussed issues related to stigma and suicide prevention. More than 90 people attended the event. More than 55 newspaper articles discussing the stigma and suicide prevention were printed statewide since October 1, 2008 reaching more than 900,000 readers. DMH also participated in 12 radio interviews and eight television interviews to discuss stigma.

In October 2009, DMH and the Mississippi Think Again Network launched the *Think Again* campaign which is a statewide effort to help people change the way they think about mental health and shatter the silence around suicide. Mississippi's new anti-stigma campaign focuses on young adults. DMH developed three presentations for parents, students and teachers to coincide with the campaign. DMH also developed a campaign toolkit with press releases, talking points, a letter to the editor template, public service announcements and other items.

Since Oct. 1, 2009, a total of 104 *Think Again* and *Shatter the Silence* (anti-stigma/youth suicide prevention) presentations were conducted statewide reaching more than 3,200 individuals. During a two day period, nearly 300 students in the Meridian Public School District participated in the presentations. More than 800 youth who participated in the 4<sup>th</sup> Annual Mental Health Awareness Day in Newton

received information about *Think Again*. Information was also presented to more than 350 youth at the Native American Youth Conference in addition to the Hinds County School Counselors, Gulf Coast Counseling Association and others.

In FY10, DMH created an evaluation and developed a database to measure student's perceptions of mental illness prior to and after the anti-stigma presentations. A total of 1,979 evaluations were completed during FY 2010. According to the evaluations, prior to the presentation 48% of students had a positive or very positive view of mental illness and persons with mental illness. After the presentation, 69.7% of students had a positive or very positive view of mental illness and persons with mental illness. The evaluation also revealed that the media and personal experiences influenced students perceptions of mental health. A total of 81.3% of students reported that they could use information they learned during the presentation to help a friend in need.

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

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

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

**Source(s) of**

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

**Special**

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

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

attitudes that surround mental illness.

**Funding:** Federal, State and/or local funds

**Was objective achieved?** Yes

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**Goal:** To increase public awareness/knowledge about serious emotional disturbance among children and services they need.

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

**Population:** Children and youth with serious emotional disturbance.

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Information dissemination – general

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

**Measure:** Dissemination of directory/other public education material and participation of DMH Children and Youth Services staff in meetings/presentations will be documented.

**Comparison Narrative:**

In FY 2009, 1,036 resource directories were disseminated at conferences, meetings, or to individuals as follows: Piney Woods Health & Resource Fair, Region 13 CMHC, MAP Team Coordinators, A-Team Coordinators, MS Association of Pediatricians, Region 12 CMHC, Region 9 CMHC, MS Health Summit, Clinton Public Schools, Pre-Evaluation Training participants, Region 8 CMHC, Mississippi State Hospital, foster care & adoptive parents, Mt. Nebo Church Health Fair, participants at the MS Counselor’s Association training, Mississippi Families As Allies, and Region 11 CMHC, Mississippi Social Work Conference, annual Lookin’ To The Future Conference, Life Help Mental Health Center, Millcreek Therapeutic Group Homes, University of Mississippi Medical Center, Gulf Coast Mental Health Conference, Catholic Charities, Inc., and Department of Health Social Workers. Presentations were made by the DMH Division of Children & Youth Staff at the following meetings/conferences/agencies:

FASD 101 and FASD Screening & Referral Trainings  
Case Management Orientation (6)

MAP Team 101 Training  
Adolescent Offender Programs annual training  
Stress Management Workshop for Crisis Teams  
U.S.M School of Social Work Fall Colloquium  
Therapeutic Group Home and Foster Care training  
Mental Health Planning Council  
Child Abuse Prevention Press Conference  
Cultural Competency Workshop  
MS Gulf Coast Youth Suicide Prevention Conference  
Mental Health Summit on the Gulf Coast  
Children's Mental Health Awareness Press Conference  
Annual School Safety Officer Training  
Annual Lookin to the Future Conference  
Annual FASD Symposium  
MS Alliance for School Health Conference  
Youth Court Judges & Referees Seminar  
Youth Suicide Prevention Workshop  
MS Youth Programs Around the Clock (MYPAC) annual training

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

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

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

**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.

**Was objective achieved?** Yes

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

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

**Population:** Children and youth with serious emotional disturbance.

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Information/assistance to schools

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

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

**Comparison Narrative:**

In FY 2009, informational materials and technical assistance were provided to 822 local schools by community mental health centers.

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

**Source(s) of**

**Information:** Annual State Plan Survey

**Special**

**Issues:** Tracking of the number of schools to which CMHCs provide educational materials/technical assistance will continue to be a data item on the Annual State Plan Survey in FY 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

**Was objective achieved?** Yes

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

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

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

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**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 Report that follows.)

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## Provisions for an Integrated Service System

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

#### **Interagency Collaboration Initiatives:**

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

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

**Population:** Children and youth with serious emotional disturbance.

**Criterion:** Comprehensive, community-based mental health system.

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

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

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

#### **Comparison Narrative:**

In FY 2009, the DMH Executive Director continued to serve as chair of the ICCCY, and the Director of the Division of Children and Youth Services served as chair 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 met in December 2008 at a networking luncheon with the MAP Team Coordinators. The ISCC also met on February 4, 2009 and June 24, 2009 to discuss new membership, legislation, agency updates, cross-training efforts, and to develop a plan for consultation on 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, and addressed the following topics: each agency's cash contribution for FY 2010 Interagency Agreement; discussed and made a motion to support reauthorization of MS System of Care legislation; received ISCC updates on activities; and observed a local Making A Plan (MAP) presentation.

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

**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

**Was objective achieved?** Yes

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**State-Level Interagency Case Review MAP Team**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

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

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

**Comparison Narrative:**

In FY 2009, the State Level Case Review Team reviewed 19 cases, of which four cases were 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.

In FY 2010, the State Level Case Review Team reviewed 21 cases and also had 27 follow-up reviews on previously staffed cases. Of the new cases, four youth were diagnosed with and IDD and SED, one youth was diagnosed sexually reactive and three were in the transitional age range. A meeting was held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

**Source(s) of**

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

**Special**

**Issues:** None

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

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

**Was objective achieved?** Yes

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

**Brief Name:** State-Level interagency team funded

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

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

**Comparison Narrative:**

In FY 2009, DMH continued to provide the State Level Interagency Case Review/MAP Team with funding to purchase critical services and/or supports identified as needed for 19 targeted children/youth with SED reviewed by the team.

In FY 2010, DMH continued to provide the State Level Interagency Case Review/MAP Team with funding to purchase critical services and/or supports identified as needed for 21 targeted children/youth with SED reviewed by the team.

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** Federal (CMHS Block Grant)

**Was objective achieved?** Yes

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### **Making A Plan (MAP) Teams**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

**Brief Name:** Technical assistance provided for MAP teams

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

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

### **Comparison Narrative:**

In FY 2009, the Division of Children and Youth Services Director had coordinated six statewide meetings with the coordinators of local MAP Teams. The Department of Human Services, Division of Youth Services' Adolescent "A" Team Coordinators attended one meeting held in February 2009. The following items were discussed throughout the year: the Fetal Alcohol Spectrum Disorder project, interagency meetings and trainings, ICCCY/ISCC activities, MS System of Care study and assessment, MYPAC, case reviews, MAP Team expansion, youth suicide prevention activities, and juvenile justice. Technical assistance was provided to MAP Teams in CMHC regions 2, 5, 6, 8, 9, 11, 12, 13 and 15. Technical assistance regarding the expansion of MAP Teams was provided to Region 2, 6, 9, and 11.

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

### **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

**Was objective achieved?** Yes

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

**Brief Name:** MAP team funding

**Indicator:** Availability of funding through DMH for MAP teams.

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

<b>PI Data Table C3.1</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# MAP Teams with Flexible Funding	16	16			
# MAP Teams with access to flexible funding			37	35	36

**Comparison Narrative:**

In FY 2009, one DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. Region 8 received additional funding for children with fetal alcohol spectrum disorders. A total of 37 MAP Teams continued to operate statewide and had accessibility to

flexible funding through the 15 CMHCs and Catholic Charities.

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

**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.

**Was objective achieved?** Yes

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

**Brief Name:** Participation on interagency committees

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

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

**Comparison Narrative:**

In FY 2009, the DMH Children and Youth Services staff participated on the following interagency committees and attended meetings with the following groups:

- Interagency System of Care Council
- State Level Case Review Team

- Lookin To The Future Conference Planning Committee,
- Advisory Council for FASD
- Case Management Task Force
- MADCP (MS Association of Drug Court Professionals)
- Drug Court Conference Committee
- American Pediatrics Association 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),
- Department of Human Services Citizens Review Board,
- Mississippi Alliance for School Health Conference Planning Committee
- commUNITY cares (SOC project) Core Committee, Sustainability Committee, and Cultural & Linguistic Committee.

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

- Interagency System of Care Council
- State Level Case Review Team
- Lookin To The Future Conference Planning Committee
- Advisory Council for FASD
- Case Management Task Force
- Drug Court Conference Committee
- American Pediatrics Ass. Mental Health Task Force
- Underage Drinking Task Force
- Prevent Child Abuse Advisory Council
- Multicultural Task Force
- Youth Suicide Prevention Advisory Council
- Dept. of Human Services Citizen’s Review Board
- MS Alliance for School Health Conference Planning Committee
- commUNITY cares (SOC project) Core Committee, Sustainability Committee, and Cultural & Linguistic Committee
- MS Transitional Outreach Project (SOC project) Executive Council, Core Committee, Cultural & Linguistic Committee
- Juvenile Justice Mental Health Task Force
- Transitional Age Task Force
- Jackson Public Schools HS/SS Project

**Source(s) of Information:** Monthly Division Activities Report

**Special Issues:** None

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

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

**Was objective achieved?** Yes

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**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).

**Comparison Narrative:**

In FY 2009, service providers funded with CMHS Block Grant funds for children and youth continued to be required to include in their proposals for these funds, strategies that they would participate in or establish local MAP teams. Service providers funded with CMHS block grant funds continue to be monitored twice a year for compliance. All providers that receive DMH funding have participated on one or more local MAP teams (100% compliance).

In FY 2010, service providers funded with CMHS Block grant funds for children and youth continued to be required to include in their proposals for these funds, strategies that they would participate in or establish local MAP teams. Service providers funded with CMHS block grant funds continue to be monitored once a year for compliance. All providers that receive DMH funding have participated on one or more local MAP Teams (100% compliance).

**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

**Was objective achieved?** Yes

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**Health and Mental Health Initiatives**

**State Children’s Health Insurance Program: Mississippi Health Benefits Program**

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

**Substance Abuse Initiatives**

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

**Social Services Initiatives**

Recognizing the wide array of services needed by children and youth with serious emotional disorders and their families, the Department of Human Services, Division of Family and Children’s Services staff seek to put into place a coordinated, cohesive system of care with ~~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.

Examples of educational services that community mental health centers/other nonprofit programs accessed in FY 2010 include: general (K-12) and special education, parenting classes, GED programs, Right Track Program, after-school tutoring, psychological testing/examinations, early childhood education, computer classes, mentoring, literacy classes, English and second language programs, college classes, family education, conflict resolution classes for children, special services for children with language disorders, budgeting/education/job training/nutrition and meal planning communication/problem solving/stress management, vocational education, college preparatory classes, alternative education programs, and independent living skills training. These services were accessed through a variety of agencies/organizations, such as local school districts, community colleges, local nonprofit organizations, transitional outreach program, the Mississippi Department of Human Services, WIN Job Centers, state universities, Headstart, Community Action Agency, Center for Prevention of Child Abuse, Boy Scouts, Job Corps, Youth Challenge Program, Mississippi Employment Security Commission, Salvation Army, county human resource agency, local public library, university speech and hearing programs, private practitioners/learning centers, local faith-based organizations and the Boys and Girls Club.

**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" (197 in 2010) 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).**

<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>					
% age of Families of children/adolescents reporting improvement in child's school attendance	54.2%	44.3%	41%	48%	38%
Numerator: Number of families of children/adolescents reporting improvement in child's school attendance (both new and continuing clients)	89	78	158	95	142
Denominator: Total number (including Not Available) (new and continuing clients combined)	164	176	385	196	376

**Was objective achieved?** The percentage of families/caregivers reporting improvement in their child's school attendance was 10% lower than targeted for FY 2010, but 3% lower than the previous year. The reason for this decrease are not readily apparent from this data; however, as noted above, there continues to be a high number of "not applicable" and "no responses" to these survey items, and the overall response rate to the questions on school attendance is lower than for other questions on perception of care. The response rate on questions pertaining to involvement in the juvenile justice system are also lower than for other questions on perception of care; therefore, survey design may be impacting these responses (i.e., use of "branching questions" for school attendance and juvenile justice involvement). Activities to improve school attendance will continue, as described in the FY 2011 State Plan.

## **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.

### **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. Community mental health centers and other nonprofit programs reported activities to work with the juvenile justice/court systems at the local level in FY 2010. Examples included work with the Youth Courts, Adolescent Offender Programs, work with juvenile detention centers (referral and assessment), work with probationary services, work with local school attendance officers, specialized assessment and/or court advocacy, permanency planning and work with local law enforcement (e.g., responding to emergencies, work with runaway youth).

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**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 (11 in 2010) and the high number of “no responses” on these survey questions, 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).**

<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>					
% age of children/adolescents Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	57%	33%	50%	46%	73%
Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)	8	4	14	6	11
Denominator: Total number of children/adolescents arrested in T1 (new and continuing clients combined)	14	12	28	13	15

**Was objective achieved?** Yes. (See also Special Issues for further discussion.)

**Mental Health Transformation Activities: Initiatives to Assure Transition to Adult Mental Health Services****Transitional Services Task Force**

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children's Services

**Brief Name:** Transitional services planning

**Indicator:** Participation by designated Division of Children and Youth Services staff who will

chair the Transitional Services Task Force, in coordination with the Division of Community Services.

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

**Comparison Narrative:**

In FY 2009, the Transitional Task Force met on November 2008 and May 2009, to develop strategies related to increasing appropriate service options

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

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

**Source(s) of**

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

**Special**

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

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

**Funding:** Federal and state

Was objective achieved? Yes

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

**Transitional Living Programs**

**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 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Transitional Living Homes/ Supported Living Programs Funded	2	Two group home programs served 40 youth, and two supported living programs served 95 youth	Four transitional living programs (two group homes and two supported living programs)	Four transitional living programs (two group homes and two supported living programs)	Four transitional living programs (two group homes and two supported living programs)

**Comparison Narrative:**

In FY 2009, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and Hope Village (two programs); 4 of the homes received DMH funding support.

In FY 2010, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and Hope Village (two programs); four of the homes received DMH funding support.

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** Federal, state, local funds

**Was objective achieved?** Yes

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**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**

**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).

<b>PI Data Table C4.1</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# Homeless/ Runaway Youth with SED Served	177	163	43	45	12*

\*See Special Issues that follows.

### **Comparison Narrative:**

During the first part of FY 2009, specialized services for homeless/runaway youth 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. Adult volunteers who are trained in crisis intervention offered assistance and transportation to the shelter for youth who could not return home.

In FY 2010, DMH did not provide funding for the SAFE Place coordinator salary.

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

**Special Issues:** By March 2010, Division of Children and Youth Staff made two technical assistance visits and conducted a certification review of Catholic Charities Inc., Host Homes Program. Certification of the Host Homes Program, funded by a grant from the Department of Health and Human Services, Administration of Children and Families, began on March 1, 2010. The award year for the grant ended September 30, 2010. Catholic Charities, Inc. did not pursue funding for the upcoming award year for the Host Homes Program due to the insufficient number of runaway and homeless youth needed to support the goals and objectives of the grant. As of October 1, Catholic Charities, Inc. Host Homes Program merged with the Therapeutic Foster Care Program to provide short-term (45 days) foster care services. Safe Place sites for youth in crisis will be maintained by the therapeutic foster care program. As the need arises with the runaway and homeless population, services will be provided via service linkage or placement.

**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

**Was objective achieved?** The targeted number was not reached due to closure of the primary program (Host Homes) during the year; see Special Issues above.

**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 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Children in Domestic Violence Situation Served	8	74	71 children served; 60 with SED	100	125 children served; 3 with SED

**Comparison Narrative:**

In FY 2009, Gulf Coast Women Center served 71 youth, 60 of whom were children with SED or at risk for emotional illness. These children are served in an emergency homeless shelter setting that is specific to domestic violence.

In FY 2010, Gulf Coast Women Center served 125 youth, three of whom were children with SED or at risk for emotional illness. These children are served in an emergency homeless shelter setting that is specific to domestic violence.

**Source(s) of Information:** Grant proposal for existing program.

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

**Significance:** This Gulf Coast Women's Center for Nonviolence provides shelter for children

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

**Funding:** Federal

**Was objective achieved?** Yes

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

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

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

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

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

PI Data Table C4.3	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
# Abused/ Neglected Children Served	298*	353	294	100	293

**Comparison Narrative:**

In FY 2009, funding continued to be provided to Region 13 Gulf Coast Mental Health Center to support services to a local shelter for abused/neglected children. The shelter provided services to 294 children in FY 2009; all children were enrolled in the services at Region 13 and had a serious emotional disturbance.

In FY 2010, funding continued to be provided to Region 13 Gulf Coast Mental Health Center to support services to a local shelter for abused/neglected children. The shelter provided services to 293 children in FY 2010; all children were enrolled in the services at Region 13 and had a serious emotional disturbance.

**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

**Was objective achieved?** Yes

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### **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.

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### **Coordination with Other Agencies**

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

**Objective:** To provide technical assistance to programs in the state serving children/youth with serious emotional disturbance

**Population:** Children with serious emotional disturbance

**Criterion:** Targeted Services to homeless/runaway youth

**Brief Name:** Educational opportunities for staff

**Indicator:** Provision of information on applicable training/education opportunities made available through the DMH Division of Children and Youth Services to programs serving children/youth with serious emotional disturbance.

**Measure:** Number of technical assistance activities and/or training offered by DMH staff.

### **Comparison Narrative:**

In FY 2009, all therapeutic group home providers, including Our House shelter, continued to receive technical assistance on managing aggressive behaviors in youth with SED. Providers of services to runaway or homeless youth will also have the opportunity to receive training at the annual Lookin' to the Future

Conference.

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

**Source(s) of**

**Information:** Children and Youth Monthly Staffing Forms

**Special**

**Issues:** None

**Significance:** Homeless/runaway youth, including youth with serious emotional disturbance, are more likely to be in emergency shelters approved by the Department of Human Services and/or other appropriate state agencies; therefore, these shelters will be targeted for inclusion in applicable children's mental health training activities.

**Funding:** State and local funds, CMHS, federal discretionary, and other grant funds

**Was objective achieved?** Yes

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**Outreach Efforts and Services to Address Barriers to Access by Individuals in Rural Areas**

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

**Goal:** To further support the availability of, and access to children's mental health services across all counties in all 15 community mental health regions.

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

**Population:** Children with serious emotional disturbance

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

**Brief Name:** Technical assistance on service expansion

**Indicator:** Availability of technical assistance regarding the availability of and access to school-based services across CMHC regions.

**Measure:** Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools.

<b>PI Data Table C4.4</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# Providers Receiving T.A. /certification visits	15	10	15	15	15

**Comparison Narrative:**

In FY 2009, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to all 15 CMHC regions.

In FY 2010, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to all 15 CMHC regions.

**Source(s) of**

**Information:** Monthly Division Activities Report

**Special**

**Issues:** Technical assistance is typically provided upon request, which will make the number of CMHCs that receive such assistance vary across years.

**Significance:** The availability of mental health services in schools is a major strategy in reaching children with serious emotional disturbance and their families who live in rural areas, particularly those with limited or no transportation. Technical assistance/training opportunities offered to CMHCs on service expansion throughout the year are recorded monthly by DMH staff.

**Funding:** Federal, state, and local funds

**Was objective achieved?** Yes

**Transportation Assistance** is provided by some community mental health centers that have vehicles for transportation or through other child service agencies in some areas.

For example, in FY 2010, 13 CMHCs and nine other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; 13 CMHCs and one other nonprofit program reported making transportation available through affiliation agreement with other agencies; and, six CMHCs and two other nonprofit programs reported utilizing local public transportation (buses, cabs, etc.).

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 toward the end of 2008 for two community mental health centers (in Greenwood and in Clarksdale). They have expanded this service across the Delta region and expect to have all the community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service has set up a telepsychiatry unit based 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 is also using 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 received additional funding from the Delta Health Alliance during FY 2010 to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. 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.

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**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)**

**Efforts to Increase Funding**

**Goal:** To increase funds available for community services for children with serious emotional disturbance.

**Objective:** The DMH will seek additional state funds for community mental health services for children with serious emotional disturbance.

**Population:** Children with Serious Emotional Disturbances

**Criterion:** Management Systems

**Brief Name:** Funding Increase Request

**Indicator:** The Department of Mental Health will seek additional funds in its FY 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.

**Comparison Narrative:**

During the 2009 Legislative session, DMH requested the following increases in General State funds for Fiscal Year 2009 for community mental health services for children: for deficit in Medicaid match on payments made to the regional community mental health centers - \$9,900,000; first year funding of services in the Mississippi Access to Care (MAC) Plan - \$3,408,800. No additional funding was appropriated for the fiscal year that ends June 30, 2009. However, DMH did receive an additional \$10 million in General funds for the year that ended June 30, 2008, for match on Medicaid payments made to the regional community mental health centers, reducing by almost half the amount that was assessed to the CMHCs to fund the deficit.

Because of the significant financial problems facing the State of Mississippi during the 2009 Legislative Session, the Department of Mental Health limited its requested increase in State General funding to \$24,000,000 to fund the Medicaid match deficit for Medicaid receipts at the 15 regional community mental health centers, and \$1,006,678 to replace an anticipated cut of a like amount in federal Social Services Block Grant (SSBG) funding.

Prior to the “stimulus plan” (American Recovery and Reinvestment Act, or ARRA), Mississippi’s 15 CMHCs were projected to receive approximately \$141 million in Medicaid receipts during the fiscal year that began July 1, 2009. The state share of that was estimated to be \$34 million, and this is the amount that the Division of Medicaid was expected to bill DMH for match. Only \$10 million was expected to be available, though, so DMH asked for an increase of \$24 million to fully fund it. Absent that increase (or some part of it), the 15 mental health centers would, collectively, have been assessed to come up with the \$24 million using a formula that was based primarily on their actual Medicaid receipts (as has been the practice for the last approximately seven years).

Because of ARRA, Mississippi’s share of Medicaid match was reduced from 24.16% to 15.76%. This meant that the state share of \$141 million in Medicaid receipts would be reduced from about \$34 million to about \$22 million, a savings of \$12 million. Under the mistaken belief that the entire match need of \$34 million had been funded, the legislature “swept” \$12 million from DMH’s appropriation. Unfortunately, only \$10 million had been funded, which means that all of the appropriated funds for match were “swept” plus an additional \$2 million. Although DMH has been advising the legislature for years that the match was not fully funded, because of the intensity of the last days of the 2009 session, that simply got overlooked and by the time DMH knew this “sweep” had occurred, it was too late to fix it. (DMH did not have an appropriation until the 2<sup>nd</sup> Extraordinary Session, and the bill that was finally passed was signed by the Governor at 11:51 p.m. on June 30, 2009, the day before the new fiscal year began. DMH did not receive the bill or know the final results until mid-July).

Governor Barbour and key legislators have been made aware of this result and have pledged to do anything that can be done that is also fiscally responsible to address it during the 2010 legislative session. In the meantime, DMH has transferred about \$10 million of funds appropriated to other needs to be used for this Medicaid match. The remaining shortage of \$12 million will be assessed to the mental health centers. Approximate 45% of Medicaid match is for children and youth, and approximately 55% is for adults. In summary, no additional funding was received for Medicaid match and, a 100% cut was received. The anticipated cut to SSBG funding did not occur.

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

**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

**Was objective achieved?** Yes (funding was requested)

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**Mental Health Transformation Activities: Workforce Development**

**Training of Mental Health Service Providers and Families across the System of Care**

**Goal:** To facilitate human resource development in addressing staffing/training needs of providers of mental health services to children with serious emotional disturbance and their families.

**Objective:** To maintain availability of technical assistance to all existing DMH-certified programs operated by the 15 community mental health centers and non-profit

agencies in support of service development and implementation.

**Population:** Children with Serious Emotional Disturbance

**Criterion:** Comprehensive, Community-based mental health system.

**Brief name:** Availability of technical assistance to DMH-certified programs

**Indicator:** Continued availability of technical assistance by DMH Division of Children and Youth staff to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.

**Measure:** The number and type of technical assistance/support activities made available to CMHCs/other nonprofit service providers.

**Comparison Narrative:**

In FY 2009, Division of Children and Youth staff provided and/or facilitated the following training for providers of mental health services for children/youth:

October 2008: Provided FASD 101, FASD screening and referral training; Updates on mental health certification at the Annual Adolescent Offender Programs training.

November 2008: Provided an overview of children's mental health services at the University of Southern Mississippi Social Work Fall Colloquium and cultural competency and diversity training at the Annual Mental Health/Mental Retardation Conference.

December 2008: Provided training on Managing Aggressive Behaviors in youth for therapeutic group home and foster care providers; provided MAP Team 101 for new coordinators.

January 2009: Assisted in facilitating sessions on youth with alcohol and drug abuse at the 2<sup>nd</sup> Annual MS School of Addiction Professionals; provided FASD training for the MS Healthcare Association.

February 2009: Assisted in facilitating the Annual KIDS COUNT Summit; provided updates on children's mental health services at the MS Vocational Rehabilitation Conference.

April 2009: Coordinated a Cultural Competency Workshop; assisted in coordinating the MS Gulf Coast Youth Suicide Prevention Conference; participated in the Child Abuse Awareness Press Conference.

May 2009: Provided an update on children's mental health at the Central MS Social Work Conference; provided cultural diversity training at the Annual Consumer Conference; coordinated the Children's Mental Health Awareness Press

Conference; provided an overview of Mississippi's mental health system at the Mental Health Summit on the Gulf coast; and assisted in coordinating the Youth Drug Court Conference.

June 2009: Provided youth suicide prevention training at the Annual School Safety Officer training.

July 2009: Provided FASD 101 and FASD updates at the Annual Lookin to the Future Conference; provided an update on MAP Teams at the Annual Lookin to the Future Conference.

September 2009: Coordinated the annual FASD Symposium; assisted with coordinating the NCAAD (spell out name) and MAAP (spell out name) Conferences; provided updates on children's mental health services at the Annual MS Alliance for School Health Conference; coordinated the Youth Suicide Prevention Workshop; provided an update on children's mental health services at the Youth Court Judges & Referees Seminar; and, provided an update of MAP Teams at the annual MS Youth Programs Around the Clock (MYPAC) training.

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

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

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

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

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

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

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

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

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

Management Orientation.

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

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

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

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

**Sources of Information:** Division of Children and Youth staffing report forms

**Special Issues:** None

**Significance:** Division of Children/Youth Services will continue to offer technical assistance in the planning, implementing and/or improving services and programs for children and their families. This includes those programs that are identified in the DMH Minimum Standards as core or minimum services that must be available in all CMHC regions.

**Funding:** Federal, state and local funds

**Was objective achieved?** Yes

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**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.

<b>PI Data Table C5.1</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# Attendance at Statewide Institute or DMH-sponsored conference	796	885			
# of statewide conferences and/or training sessions sponsored or co-sponsored by DMH CYS			Four	Four	Five

**Comparison Narrative:**

In FY 2009, the DMH Division of Children and Youth sponsored the First Annual Gulf Coast Suicide Prevention Conference in April 2009. DMH also sponsored a Cultural and Linguistic Training in April 2009 for all providers. In July 2009, DMH continued to serve as a primary sponsor of the 21<sup>st</sup> Annual Lookin' to the Future and The Miss. Permanency Partnership Network Conference conducted by Southern Christian Services. DMH also continued to sponsor the annual Mississippi Alliance for School Health Conference held in September 2009, with a pre-conference focused on Youth Suicide Prevention.

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

**Source(s) of**

**Information:** Registration Forms for the Conferences; Final Conference Reports

**Special**

**Issues:** None

**Significance:** Training of service providers, both in the public community mental health system and across agencies that serve children and families, is a vital factor in facilitating

both quality services, as well as interagency collaboration.

**Funding:** CMHS funds

**Was objective achieved?** Yes

### **Training of Emergency Health Workers in the Area of Children's Mental Health**

**Mental Health Transformation: Workforce Development in Provision of Evidence-Based Practices (NFC Goals 5.3 and 5.4)**

#### **Mississippi Trauma Recovery for Youth (TRY) Project**

**Goal:** To facilitate implementation of evidence-based practices for enhancing trauma-informed care.

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

**Population:** Children with serious emotional disturbance

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Evidence-based practice training

**Indicator:** Provision of training for additional clinical staff in the evidence-based practice of trauma-focused cognitive behavior therapy through the learning collaborative model.

**Measure:** The number of additional community mental health services staff who complete training in trauma-focused cognitive behavioral therapy (65)

<b>Mental Health Transformation PI Data Table</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# Additional community mental health services staff trained in TF-CBT	130	83 Baseline	78	65	73

#### **Comparison Narrative:**

In FY 2009, the Mississippi Trauma Recovery for Youth (TRY) Project had the

third Learning Collaborative for therapists in the south and central areas of the state. This Collaborative was attended by 78 therapists and clinicians and resulted in 121 children/youth receiving TF-CBT. Each Collaborative involves supervisory staff in three, two-day Learning Sessions and monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT.

In FY 2010, the Mississippi Trauma Recovery for Youth (TRY) Project began a Learning Collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) in January 2010 with four CMHC regions and staff from Specialized Treatment Facility. This Collaborative was attended by 28 therapists and clinicians. Each Collaborative involves supervisory staff in three, two-day Learning Sessions and monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT. In the summer 2010, 45 clinicians at Pine Belt Mental Healthcare Resources were trained in TF-CBT.

**Source(s) of**

**Information:** Division of Children and Youth Services monthly grant report forms

**Special**

**Issues:** Priority for expansion of training will be in those counties on or just north of the Gulf Coast.

**Significance:** Expansion of training in this area will address needs to enhance skills of community mental health services staff in providing trauma-informed care, while also providing additional information on use of the learning collaborative model to implement evidence-based practices.

**Funding:** CMHS Block Grant, local funds

**Was objective achieved?** Yes

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**Case Manager Training**

**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).

<b>PI Data Table C5.3</b>	<b>FY 2007 (Actual)</b>	<b>FY 2008 (Actual)</b>	<b>FY 2009 (Actual)</b>	<b>FY 2010 (Target)</b>	<b>FY 2010 (Actual)</b>
# Case Management Training Sessions	8	8	7	8	8

**Comparison Narrative:**

In FY 2009, DMH held seven case management orientation sessions (in October 2008; February, March, April, May, and July, 2008, and one session in September 2009). A total of 180 case managers completed case management orientation (Module I) in FY 2009.

In FY 2010, DMH held eight case management orientation sessions (in October 2009; and February, March, April, May, July, September 2-3 and September 16-17, 2010.) A total of 210 case managers completed case management orientation in FY 2010.

**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

**Was objective achieved?** Yes

**Mental Health Transformation: Workforce Development**

**Mental Health Therapist Certification and Licensure Program**

**Mental Health Administrator Licensure Program**

**Case Manager Certification Program**

**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.

**Comparison Narrative:**

In FY 2009, a change was made to the application process for individuals applying to move up (upgrade) from provisional certification to full certification that affected both the Mental Health Therapist Program and the Case Management Certification Program. It was decided that applicants would no longer be required to report continuing education hours at both the time of upgrade and the time of renewal. This was determined to be an unnecessary duplication of effort. Rather, we would continue to require continuing education to be addressed at the time of renewal.

In FY 2009, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 125 booklets were distributed. By the end of FY 2009, a total of 2,161 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Also in FY 2009, changes were made to the Mental Health Core Training Program (MH-CTP). The MH-CTP requirement was streamlined from three separate, week-long modules and written examinations to one written Mental Health Therapist examination with self-study as the basic format for test preparation. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009. The content of the remaining one written exam continues to be material outlined by a steering committee made up of community

mental health service providers, consumer advocates, consumers/family members, administrators, etc. During FY 2009, the required Mental Health Therapist exam was administered to 146 individuals.

In FY 2009, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 15 booklets were distributed. By the end of FY 2009, the Licensed Mental Health Administrator program included a total of 126 individuals; 25 Program Participants and 101 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the required written examinations or his/her participation in DMH's leadership development program called Focus. As of the most recent renewal deadline, December 31, 2007, 68 renewing licensees reported having received the required 40 Contact Hours. The next renewal deadline will be December 31, 2009.

In FY 2009, PLACE staff continued to offer written exams for the Licensed Mental Health Administrator program. Written examinations were made available to Participants at least one day each month. A total of 2 written examinations were administered to Participants in FY 2009.

In FY 2009, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; 26 booklets were distributed. By the end of FY 2009, a total of 758 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Also in FY 2009, changes were made to the Case Management Core Training Program (CM-CTP). The CM-CTP requirement was streamlined from three separate modules and written examinations to one required training (Case Management Orientation) and written examination. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009.

In FY 2010, a total of 303 Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT), or Licensed Mental Health Therapist (LCMHT) credentials were awarded. The Mental Health Therapist credentialing exam was administered to 110 individuals seeking certification.

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

A total of 82 individuals currently hold the Licensed DMH Administrator credential, and a total of 14 individuals are currently Participants in the Licensed

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

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

**Special Issues:** None

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

**Funding:** State funds

**Was objective achieved? Yes**

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 2007–FY 2008 and actual numbers for FY 2009 – FY 2010 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
Mental Health Therapists (all levels)	1,733	1,959	2,161	2,175	2,237
Mental Health Administrators (all levels)	121	122	126	125	127
Development/Implementation of Case Management Certification Program (FY 2003 – FY 2005)	–	–	–		
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	367	629	758	845	844

## **Mental Health Transformation Activity: Workforce Development through Academic Linkages**

**Academic Linkages at the Local Level** continued in FY 2010, with 14 CMHCs and nine 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: community counseling, social work, psychology, counseling education, human services, community and school counseling, rehabilitation counseling, nurse practitioner programs, early childhood education, nursing, clinical psychology, industrial counseling, nursing psychology, marriage and family therapy, and special education. 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 received additional funding from the Delta Health Alliance during FY 2010 to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. In addition, the Department of Psychiatry is looking into ways of sponsoring educational activities for other community mental health centers and state hospitals through a telehealth system.

### **Information Management Systems Development**

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

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

**Population:** Children with Serious Emotional Disturbance

**Criterion:** Management Systems

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

**Indicators/Strategies:**

- A) Work will continue to coordinate the further development and maintenance of uniform data reporting and further development and maintenance of uniform data standards across service providers. Projected activities may include, but are not limited to:
- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the CMHS 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.

**Comparison Narrative:**

In FY 2009, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Thirteen out of 15, or 87%, of regional community mental health centers (CMHCs) and two out of four, or 50%, of the state psychiatric hospitals are presently submitting data that populates the database.

The Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are about to embark on the task of setting up the Children's non-profits so they may enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables but we hope to have that task completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

Our continued approach has been to address collection, software upgrades, reporting quality, and training issues pertaining to the data at the local level, to bring all data from administrative sources into the central data repository by file upload and browser based data entry, to provide for monitoring of the data for accuracy and timeliness by Central Office personnel and to report the data to the CMHS in the form of the URS tables and in the State Plan as National Outcome Measures as required.

Ongoing technical assistance and training is also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training is also planned to facilitate communication among stakeholders.

In FY 2010, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data needed to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. All fifteen regional community mental health centers and 3 out of 4 of the state psychiatric hospitals are presently submitting data that populates the database.

The 13 Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are working on setting up the Children's non-profits so they may enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables but we hope to have that task completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

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Ongoing technical assistance and training is also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training is also planned to facilitate communication among stakeholders.

**Special  
Issues:**

As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

**Significance:** Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

**Funding:** State funds, Federal funds

**Was objective achieved?** Yes

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**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
<b>TOTAL</b>	<b>\$1,549,296</b>

**Projected Expenditures of FY 2010 CMHS Block Grant Funds  
For Children's Services by Region/Provider**

<b><u>Providers</u></b>	<b><u>Projected Allocation</u></b>
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 Richard Duggin. Executive Director (MAP Team flexible funds)	10,000
Life Help P.O. Box 1505 Greenwood, MS 38935 Madolyn Smith, Executive Director (MAP Team flexible funds)	17,857

Community Counseling Services P. O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director (Crisis Intervention/Emergency Response, and MAP Team flexible funding)	89,159
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director (Crisis intervention/emergency response, MAP Team flexible funding)	112,745
Weems Community Mental Health Center P.O. Box 4378 Meridian, MS 39304 Maurice Kahlmus, Executive Director (MAP Team flexible funding)	15,357
Catholic Charities, Inc., Natchez (Region 11) 200 N. Congress, Suite 100 Jackson, MS 39201 Greg Patin, Executive Director (MAP Team flexible funding)	10,357
Southwest MS Mental Health Complex P.O. Box 768 McComb, MS 39649-0768 Steve Ellis, Ph.D., Executive Director (MAP Team flexible funding, Pike County)	4,000
Pine Belt Mental Healthcare Resources P.O. Drawer 1030 Hattiesburg, MS 39401 Jerry Mayo, Executive Director (MAP Team flexible funding)	20,357
Gulf Coast Mental Health Center 1600 Broad Avenue Gulfport, MS 39501-3603 Jeffrey L. Bennett, Executive Director (Intensive Crisis Intervention, MAP Team 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 Wendy Mahoney, Executive Director (Crisis Intervention/Respite, flexible funding for services for youth by the State-level Interagency Case Review Team, other System of Care (SOC) development activities (ex.: more flexible funds, as needed; SOC training; ICCCY planning/activities)	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.

**FY 2010 STATE PLAN IMPLEMENTATION REPORT FOR COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SERIOUS MENTAL ILLNESS**

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

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

**Mental Health Transformation Activity: Involving Consumers Fully in Orienting the Mental Health System toward Recovery (NFC Goal 2.2)**

**Peer Review**

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

**Objective:** To refine the peer review/quality assurance process for all adult community mental health programs and services based on survey responses from community mental health center directors, peer reviewers, and interested stakeholders (i.e., NAMI-MS, MHA).

**Population:** Adults with serious mental illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Implementation of peer review

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

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

**Comparison/Narrative:**

In FY 2009 peer reviewers for adult community mental health services had visited 10 community mental health centers and involved 20 peer reviewers. Of the 16 reviewers, 13 were individuals receiving services, 3 were family members and 4 were professionals.

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

**Source(s) of**

**Information:** Peer review reports, which are mailed to the community mental health centers and the Division of Community Services at East MS State Hospital and MS State Hospital.

**Special**

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

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

**Funding:** CMHS Block Grant Funds

**Was objective achieved?** Yes

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**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 and 2010 surveys in an effort to increase the response rate to the voluntary survey in individual regions.

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

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

### Satisfaction Survey of Individuals Receiving Services

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator				
% Reporting Positively about Outcomes	71%	74%	77%	70.5%
Numerator	447 positive responses	1071 positive responses	476 positive responses	909 positive responses
Denominator	628 responses	1453 responses	615 responses	1289 responses

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)
Performance Indicator	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
1. % Reporting Positively about Access	89%	89%	88%	88.5%
Numerator	564 positive responses	1332 positive responses	543 positive responses	1,157 positive responses
Denominator	636 responses	1494 responses	617 responses	1,307 responses
2. % Reporting Positively about Quality and Appropriateness for Adults	90%	91%	89%	88.5%
Numerator	569 positive responses	1351 positive responses	549 positive responses	1,155 positive responses
Denominator	635 responses	1491 responses	616 responses	1,305 responses

3. % Reporting Positively about Outcomes	71%	74%	77%	70.5%
Numerator	447 positive responses	1071 positive responses	476 positive responses	909 positive responses
Denominator	628 responses	1453 responses	615 responses	1,289 responses
4. % Reporting on Participation in Treatment Planning	76%	80%	76%	79%
Numerator	480 positive responses	1158 positive responses	461 positive responses	990 positive responses
Denominator	631 responses	1451 responses	608 responses	1,256 responses
5. % Reporting Positively about General Satisfaction with Services	90%	91%	89%	90%
Numerator	574 positive responses	1366 positive responses	549 positive responses	1,169 positive responses
Denominator	637 responses	1493 responses	615 responses	1,303 responses

**Was objective achieved?** Targets were met or exceeded in FY 2010 for three of the five domains on the satisfaction survey (access, participation in treatment planning and general satisfaction). The target for quality/appropriateness was slightly below the projection for FY 2010 ( by .5%). The FY 2010 for the NOM on outcomes was not met, and was less than the percentages reported for the previous two years. Although the reasons for the decrease in positive responses in the outcome domain are not readily apparent from this data, activities to improve perception of outcomes by consumers will continue as described in the FY 2011 State Plan.

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

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

**Population:** Adults with serious mental illness

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Constituency Services Call Reports

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

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

**Comparison/Narrative:**

In FY 2009, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. Additionally, OCS continues to distribute and update the "Directory on Disk". This directory gives service providers access to basic program/ service information for over 2100 programs and support groups statewide. This distribution and training are ongoing. OCS continues to update the statewide database used for information and referral. Approximately 215 new programs were added and over 600 individual program's information was updated in the reporting period. This process is ongoing. OCS recently contracted with the National Suicide Prevention Lifeline to serve as a network provider. Calls from all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since beginning to take calls in mid December 2008, OCS has received over 2300 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports.

In FY 2010, OCS continued to meet bi-annually with the advisory council formed in FY 1999. OCS staff participates in certification visits to each DMH certified program to monitor compliance with standards related to grievances/ complaints and to follow up on previous complaints. The OCS continues to attempt to resolve consumer complaints through formal and informal procedures. A report of formal grievances and a report of informal grievances are distributed to all DMH bureau directors. Reports include the complaint, action taken by OCS and the status of the investigation. OCS staff works closely with other state agencies, including Constituency Services in the Office of the Governor, to resolve any issues. Reports of calls to the helpline (deleting all confidential information) have been distributed regularly, including 4 quarterly reports and an annual report. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS also provides all DMH bureau directors with quarterly informal and formal grievance reports indicating follow up and resolution of all complaints and grievances. OCS continues to update the statewide

database used for information and referral. Approximately 60 new programs were added and over 500 individual program's information was updated in the reporting period. This process is ongoing. OCS contracted with the National Suicide Prevention Lifeline in December 2008 to serve as a network provider. Calls from all 82 counties in MS to the national toll-free number are routed to DMH and handled by OCS staff. The OCS developed policies and procedures for receiving and resolving these calls. Since the beginning of FY 2010, OCS has received 7622 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. In January 2010, OCS contracted and developed the capacity to offer individuals the option of communicating with Helpline staff via text messaging or online messaging rather than the traditional verbal communication. OCS is also able to capture data and analyze trends related to the needs expressed by individuals. Since the inception of the program, there have been 189 messages sent and received, 1618 log-ins to the system and 122 individual user accounts created. Data from this program is included in the quarterly reports.

**Source(s) of**

**Information:** Data provided through the software, as calls to the OCS help line logged into the computer system.

**Special**

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

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

**Funding:** State General Funds

**Was Objective Achieved?** Yes

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**Mental Health Transformation Activities: Support for Culturally Competent Services (NFC Goal 3.1)**

**Development of Peer Specialist Services**

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. 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. In FY 2010, the Bureau of Community Services continued efforts to obtain funding support to provide peer specialist services, including submission of an application for a SAMHSA Mental Health Transformation grant; however, the proposal was not approved for funding.

### **Multicultural Task Force**

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Multicultural Task Force operation

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

**Measure:** The number of meetings of the Multicultural Task Force during FY 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.

**Comparison/Narrative:** In FY 2009, the Multicultural Task Force (MCTF) met on November 21, 2008, June 22, 2009, August 17, 2009, September 14, 2009. The task force organized the statewide Day of Diversity held on October 13, 2008; on November 3, 2008, the co-chair of the MCTF presented at the 27<sup>th</sup> Annual MH/MR Joint Conference on cultural competency and disparities. On April 17, 2009, the “Cultural and Linguistic Competency: Keeping It Real” workshop was held. The presenter was Dr. Vivian Jackson with the National Center for Cultural Competency. Approximately, 85 service providers attended the workshop. The annual report of task force activities was made to the Mississippi State Mental Health Planning and Advisory Council on August 17, 2009.

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

African Heritage in Rural America.”

**Source(s) of**

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

**Special**

**Issues:** None

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

**Funding:** State funds

**Was Objective Achieved?** Yes

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**Local Provider Cultural Competence Assessment**

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Cultural competency pilot project expansion

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

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

**Comparison/Narrative:** In FY 2009, Region 11 CMHC received their cultural competence assessment results on May 8, 2009. Staff member met with staff from Region 2 CMHC on July 21, 2009, to discuss the cultural competency assessments. Staff has not yet received a date to conduct the assessment from the Region 1 CMHC clinical director.

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

**Source(s) of**

**Information:** Division of Community Services Activity Report

**Special**

**Issues:** Participation in the project will be voluntary.

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

**Funding:** State and local funds

**Was Objective Achieved?** Yes

**Goal:** To provide appropriate, culturally sensitive services for minority populations.

**Objective:** To make training available to community services staff in cultural awareness and sensitivity.

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Cultural diversity training availability, state level

**Indicator:** Availability of NCBI training sessions on cultural awareness and sensitivity.

**Measure:** The number of NCBI training sessions made available to community mental health services staff. (Minimum of 3)

PI Data Table A1.4	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# of NCBI Training Sessions for CMHC Staff	4	6	3	5

**Comparison/Narrative:**

The Multicultural Task Force continued to meet in FY 2009 to identify priority areas to be addressed related to cultural issues in community mental health service delivery. The DMH continued to use the National Coalition Building Institute’s (NCBI) Prejudice Reduction Training Model. Three NCBI trainings were conducted at Region 8 (Copiah County, Rankin County and Simpson County) in April 2009. An NCBI training was provided to Region 3 Mental Health Center staff in April 2009. In May 2009, staff conducted a cultural diversity training session at the Consumer Conference. NCBI training was also conducted for MS Families As Allies for Children’s Mental Health, Inc. in June 2009. An NCBI training was conducted at Region 1 Mental Health Center in September 2009.

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

In FY 2009 and FY 2010, the *DMH Minimum Standards for Community Mental Health/Mental Retardation Services* continued to require that all programs certified by DMH train newly hired staff in cultural diversity/sensitivity within 30 days of hire and annually thereafter. Compliance with standards continues to be monitored on site visits.

**Source(s) of**

**Information:** NCBI: MS Chapter Training Records

**Special**

**Issues:**

The Multicultural Task Force will continue to explore ways to assess the impact of the NCBI training, including participants' next steps in encouraging or promoting diversity in the community. The number of training sessions provided depends on the number of requests for training received and availability of staff qualified to provide the training.

**Significance:** The State Plan calls for the operation of a Multicultural Task Force to address issues relevant to providing mental health services to minority populations in Mississippi, which has focused much of its efforts on training needs. Training has been provided to increase the cultural awareness and sensitivity of community services staff.

**Funding:** State and/or federal funds

**Was Objective Achieved?** Yes

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**Availability of Psychosocial Rehabilitation Programs**

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Availability of Psychosocial Rehabilitation Programs	16 Programs; 60 sites statewide served 4822 individuals	16 Programs; 60 sites statewide served 5087 individuals.	16 Programs	16 Programs 60 sites Number served will come from survey

**Comparison/Narrative:**

In FY 2009, there were 16 psychosocial rehabilitation/clubhouse programs in the state, one in each of the 15 community mental health regions and one operated by the Mississippi State Hospital Community Services Division (in Jackson), with 60 clubhouse sites operational statewide, and 5087 individuals were served.

In FY 2010, there were 16 psychosocial rehabilitation/clubhouse programs in the state, one in each of the 15 community mental health regions and one operated by the Mississippi State Hospital Community Services Division (in Jackson), with 59 clubhouse sites operational statewide, and 5158 individuals were served.

**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

**Was Objective Achieved?** Yes

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**Drop-In Center**

**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

**Comparison/Narrative:**

In FY 2009, Resource Center provided services to 26 adults with serious mental illness; 14 were women and 12 were men, five were under 41 years of age, 16 were 41 to 60 years of age, and five were in the age range of 61 years or above. The drop-in center in Gulfport, operated by the Mental Health Association of Mississippi, provided services to 183 adults with serious mental illness; this total represents a unduplicated count and also includes individuals who were served in BRIDGES support groups and through the program for homeless persons. Individuals served included 79 females and 104 males. Of the individuals served, 64 were age 56 or older, 32 were in the 50-55 year age range, 22 were in the 35-49 year age range, and 64 were in the 16-34 year age range.

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

**Source(s) of**

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

**Special**

**Issue(s):** None

**Significance:** None

**Funding:** Federal and state.

**Was Objective Achieved?** Yes

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**Improvements to the Psychosocial Rehabilitation Program**

**Goal:** To continue to improve psychosocial rehabilitative services to better serve adults with serious mental illness.

**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.

**Comparison/Narrative:**

In FY 2009 there were 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. In FY 2009, the Clubhouse Coalition met two times and continued to include members and staff who have participated in ICCD clubhouse training, both in-state and out-of-state. The Department of Mental Health continued to support the ICCD clubhouses with ICCD certification. The Department of Mental Health assisted region 5 (3 staff and 2 members) in attending the national clubhouse conference. DMH continues to support region 5 in maintaining a clubhouse thrift store in the community. The ICCD-certified clubhouse in Greenville, MS (Region 5) continued to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi. Ann Macvaugh, Director of ICCD clubhouse in Greenville, provided technical assistance about ICCD certification to Region 9 CMHC. Region 9 clubhouse is pursuing ICCD certification in FY 2009. The ICCD conducted the certification consultation visit in August, 2009. Region 9 is awaited certification results. Region 6 has submitted an application for ICCD certification on their Lexington clubhouse.

In FY 2010, there were four ICCD-certified clubhouses in Mississippi: in Region 5 (Greenville), in Region 6 (Greenwood), in Region 12 (Hattiesburg), and Region 9 (Jackson). Region 5 has been officially defined by ICCD as a Welcome Center. In FY 2010, the Clubhouse Coalition met two times and continued to include members and staff who have participated in ICCD clubhouse training, both in-state and out-of-state. The Department of Mental Health continued to support the ICCD clubhouses with ICCD certification. The Department of Mental Health assisted Region 6 (three staff and one member) in attending the clubhouse training in Greenville, S.C.

Two staff and one member from Region 12 attended the clubhouse training in Greenville, S.C. DMH assisted Mississippi State Hospital Community Services Division clubhouse in paying their dues to obtain ICCD certification; they have begun their self study and are awaiting a certification date. Region 6 has submitted an application for ICCD certification of their Lexington Clubhouse and is awaiting a certification date. Region 6 has paid ICCD membership dues for their Montgomery Clubhouse and is waiting to begin their self study. DMH continues to support Region 5 in maintaining a clubhouse thrift store in the community. The ICCD-certified clubhouse in Greenville, MS (Region 5) continued to provide a one-week clubhouse training program, which includes transitional employment training to clubhouses in Mississippi. Five staff and two members from Region 7 attended the training.

**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

**Was objective achieved?** Yes

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### Training in the Clubhouse Model

**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 provision of technical assistance in-state by representatives of ICCD training sites (such as Fountain House in New York, NY or 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.

**Comparison/Narrative:**

In FY 2009, 12 people received from Region 7 received training from Washington Square clubhouse in Greenville, MS; eight staff persons and four members were trained. Six more staff are scheduled to attend the training in November. One staff member from Region 9 received technical assistance. Two DMH staff members attended the training in Greenville, South Carolina in October, 2008. The coordinator from Pine Belt Mental Health is scheduled to attend training in Greenville, S.C. in January.

In FY 2010, seven individuals from Region 7 received training from Washington Square Clubhouse in Greenville, MS; five staff persons and two members were trained. The coordinator from Pine Belt Mental Healthcare Resources (Region 12) attended training in Greenville, S.C.

**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

**Was Objective Achieved?** Yes

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**Transitional Employment Program for Individuals With Serious Mental Illness**

**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.

**Comparison/Narrative:**

In FY 2009, state human resource directors and private sector human resource directors were invited to participate in the conference to learn more about the transitional employment program (TEP). TEP and supported employment were addressed with regard to the recovery model at this year's consumer conference.

In FY 2010, DMH continued to make available training/technical assistance targeted at improving implementation of the transitional employment component of the clubhouse rehabilitation program. Additionally, DMH made available funding for the development of training focused on transitional employment, which is part of the one-week training Washington Square provides. Staff and clubhouse members from Washington Square continue to work with ICCD representatives to strengthen the transitional employment component of the training.

**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.

(We will begin providing technical assistance on the transitional employment program through the peer review process at the first of the year.)

**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

**Was objective achieved?** Yes

## **Other Efforts to Facilitate Transitional Employment Initiatives**

**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 and FY 2010 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 4. 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Performance Indicator</b>				
Individuals employed as a percent of those served in the community	17.5%	16.2%	17.7%	15.1%
Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)	9541	9571	9286	9158
Denominator: # of persons employed + unemployed + not in labor force (excludes "not available" status)	54,473	59,211	52,452	60,690

**Was objective achieved?** The percentage of people competitively employed (of the number served) decreased. Although the exact reasons are not readily apparent from the data, the number of employed people decreased, and the number of both unemployed people and people not in the labor force increased, which is consistent with and may be reflective of overall general high unemployment rates.

**Vocational/Employment/Educational Services** may also be accessed by community mental health centers and the community services divisions of East MS State Hospital, Mississippi State Hospital and Central Mississippi Residential Center 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 2010 included: resume writing assistance, interview skills training and job referrals, employment counseling, work activity, commercial licensure and driving training, safe food preparation and food service, vocational evaluation, transitional employment, job placement, community volunteer programs, GED prep and GED programs, adult basic education programs, literacy training programs, adult education programs, academic and vocational education, independent living training, community college technical skills courses, supported employment (with businesses in the community), literacy training, nutrition education, budgeting education, parenting education, health education (e.g., diabetes, STDs), Ticket to Work Program, computer training, consumer education, community college and senior college degree programs, medication education, and leadership and advocacy skills training.

The CMHCs, the Community Services Divisions of the two larger state hospitals and Central MS Residential Center 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 2010 included: the MS Department of Rehabilitation Services, WIN Job Service, Social Security Administration, Mississippi Highway Patrol, Mississippi Cooperative Extension Service, Ability Works of Mississippi, local faith-based organizations and churches, Community Resource Centers, Mississippi Department of Employment Security, local high schools, Goodwill Industries, Salvation Army, Literacy Education Unit, community job placement agencies, community colleges, state and private universities, Mississippi Department of Finance, Literacy Council, local libraries, local vocational-technical centers, Mississippi Department of Human Services, NAMI-MS, community action agencies, Disability Rights Mississippi, Inc., Mississippi State Department of Health, and Mississippi Leadership Academy.

**Mental Health Transformation Activity: Improving Consumer Access to Affordable Housing and Supports**

**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)

<b>PI Data Table A1.8</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Availability of Group Homes</b>	23	24	24	30

**Comparative/Narrative:**

In FY 2009, there were 24 Group Homes certified by the Department of Mental Health available

for adults with serious mental illness. The total number of beds available in the 24 group homes was 257. The number of group homes by region is as follows: Region 2 (8 beds), Region 3 (9 beds), Region 5 (30 beds), Region 6 (24 beds), Region 12 (31 beds), Region 13 (24 beds), Region 15 (27 beds), East Mississippi State Hospital (77 beds), Mississippi State Hospital (27 beds).

In FY 2010, two group homes were added: Region 3 added two 10-bed homes; additionally, Central MS Residential Center (CMRC) operates four, 12-bed group homes in Newton. Thereby increasing the reported number of group homes certified by the Department of Mental Health available for adults with serious mental illness from 24 to 30. (Note: The CMRC homes were available in previous years, but had not been included in the above performance indicator table prior to FY 2010.) The total number of beds available in the 20 group homes was 325. The number of group homes by region is as follows: Region 2 (8 beds), Region 3 (29 beds), Region 5 (30 beds), Region 6 (24 beds), Region 12 (31 beds), Region 13 (24 beds), Region 15 (27 beds), East Mississippi State Hospital (77 beds), Mississippi State Hospital (27 beds); CMRC (48 beds).

**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 was 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.

**.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

**Was objective achieved?** Yes

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**Transitional Residential Treatment Services or Halfway Houses**

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Transitional Residential Services #beds	36 beds; 114 individuals served	36; 80 individuals served	30 beds	34; 80 individuals served

**Comparison/Narrative:**

In FY 2009, as of October 2009, DMH certified three halfway houses. These were located in Greenwood (capacity 16), Enterprise (capacity 10) and Jackson (capacity 10); for a total capacity of 36 beds; these three programs reported serving a total of 80 adults with serious mental illness in FY 2009.

In FY 2010, DMH certified three halfway houses. One of the programs, Crossroads (operated by Mississippi State Hospital Division of Community Services in Jackson), decreased its total number of beds from 10 to 8, dropping the total number of beds statewide from 36 to 34. The Greenwood program remained at a capacity of 16 beds and the Enterprise program remained at a capacity of 10 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 re-hospitalization 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

**Was objective achieved?** Yes

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Availability of Supervised Housing	153	153	150	165

**Comparison/Narrative:**

In FY 2009, DMH certified 13 Supervised Housing Programs in six regions across the state, plus one Supervised Housing program operated through Mississippi State Hospital, with a total capacity of 153 beds. 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). Mississippi State Hospital had a capacity of 8 supervised housing beds. There are also HUD-funded supervised housing options in Region 4 (Capacity 78), Region 15 (17). An additional 24 supervised housing units were available during the first part of FY 2009, operated by Central Mississippi Residential Center; however, these units were closed in May 2009 due to budget cuts.

In FY 2010, DMH certified 14 supervised housing programs operated by six community mental health centers across the state, and one Supervised Housing program operated through Mississippi State Hospital, with a total capacity of 165 beds. Addition of a new program operated by Region 6 in Greenwood, (capacity of 12 beds) increased the total beds statewide. Available supervised housing beds by Region is: Region 5 (capacity 30), Region 6 (capacity 44), Region 7 (capacity 55), Region 8 (capacity 8), Region 14 (capacity 12) and Region 15 (capacity 8). Mississippi State Hospital had a capacity of 8 supervised housing beds. Additionally, HUD-funded supervised housing options were available in Region 4 (Capacity 78), Region 15 (17).

**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 2010, 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

**Was Objective Achieved?** Yes

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### **Strategic Planning for Housing Initiative**

The Division of Planning in the Bureau of Community Services coordinated the Housing Task Force established by DMH in 2010. The DMH continued activities to build partnerships at the state and local level and to use specialized technical assistance supported by federal TTI funding to facilitate development of a strategic plan for housing.

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### **Other Housing Options**

#### **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 and FY 2010 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 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator				
% of adults reported homeless/in shelters	.8%	.8%	.78%	.79%
Numerator: # adults reported homeless/in shelters by DMH certified/funded providers	512	560	474	532
Denominator: # adults reported with living situations by DMH certified/funded providers, excluding persons with living situation	63,410	65,997	61,028	67,431

Not Available				
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**Was Objective Achieved?** The percentage of adults reported as homeless/in shelters (of the number served) was slightly higher than the targeted percentage (by .01%), although it was slightly less than the percentage reported in FY 2009.

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### **Other Housing Assistance**

In FY 2010, examples of housing assistance accessed by individual local community mental health providers for eligible individuals with serious mental illness included: federal low income housing (e.g., subsidized housing, rental assistance, Section 8), temporary emergency housing, shelter for victims of domestic violence, personal care homes, home buyer education, supportive housing, assistance with home ownership, rental assistance, utilities assistance, emergency and transitional shelter programs, homeless shelter and transitional services, shelter services for persons with HIV/AIDS, and supervised apartments. Examples of agencies/entities in individual communities through which housing/housing assistance were access included: local public housing authorities (and HUD), the Salvation Army, local community mental health centers, licensed personal care home providers, apartment complexes in the community, FEMA, Home of Your Own (University of Southern Mississippi Institute for Disability Studies), local faith-based organizations, Habitat for Humanity, Stewpot Community Services, Gateway Rescue Mission, Grace House, Southern Christian Services for Children and Youth, University Center for Excellence and Developmental Disabilities, community action agencies, AIDS Task Force, Billy Brumfield Shelter, Matt's House, Harbor House, the American Red Cross, Gulf Coast Rescue Mission, a Community Action Agency, Gulf Coast Women's Center, Lighthouse Ministries, and the AIDS task force.

### **Substance Abuse Services**

As indicated in the FY 2009 and FY 2010 State Plans, substance abuse services were also administered by the Mississippi Department of Mental Health through the Bureau of Alcohol and Drug Abuse Services. Community mental health centers are the primary providers of both community mental health and outpatient substance abuse treatment for adults. Other nonprofit programs also provide some prevention and treatment services in the community, and public inpatient treatment services are provided through the Mississippi State Hospital in Whitfield (for men and women) and the East Mississippi State Hospital (for men). Initiatives to address the needs of individuals with co-occurring disorders are addressed in distinct objectives in the Plan.

### **Health/Medical and Dental Services/Other Support Services**

Specific examples of medical/dental services reported as provided/accessed in FY 2010 by individual CMHCs and the Community Services Divisions of the state psychiatric hospitals included: federal Community Health Centers (CHCs), local county Health Department offices, rural health clinics, home health agencies, local county and/or community hospitals, Delta Health Alliance, private psychiatric hospitals, local private practitioners (general medical, eye examinations and ophthalmological services,, podiatry services, dental services/surgery and orthodontics), local private practice clinics, free clinics, Voice of Calvary Family Health Center, University of Mississippi Medical Center, local faith-based organizations, the Veteran's Administration, and the University of Mississippi Medical Center, School of Dentistry.

**Other Mental Health/Social Services**

Examples of other mental health/support services (other than those listed previously) provided to adults with serious mental illness in FY 2010 as reported by individual community mental health centers and the Community Services Divisions of Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center included: food, clothing, home furnishings, transportation assistance, utilities assistance, general financial assistance, nutrition services, Meals on Wheels, assistance with activities of daily living, family planning services, linkage and referral, medication assistance, emergency food and financial assistance, legal advice and representation, vision screening and eye glasses, homemaker services, Senior Worker program, outreach for homeless persons, child advocacy and parenting classes, health education/family planning services, laboratory services and dietary counseling. These services were reported as provided through a variety of community agencies and groups, such as local community hospitals, home health agencies, faith-based community organizations and churches, the Salvation Army, the Social Security Administration, the Mental Health Association, local charities, the Mississippi Department of Health, NAMI-MS, the American Red Cross, local businesses, Mississippi Department of Human Services, local civic organizations (e.g., the Civitan Club, Junior Auxiliary, Lions Club), a state university student association, ACLU, Legal Aid, pharmaceutical assistance programs, FEMA and United Way.

**Mental Health Case Management Services**

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Served–Case Management	15,331	15,811	15,500	15,994

**Comparison/Narrative:**

In FY 2009, community service providers reported 407 adult services case managers. They provided services to 15,811 adults with serious mental illness (including individuals with Medicaid) through the CMHCs and the Community Services Divisions of MS State Hospital and East MS State Hospital and through private non profit agencies

that either received funding or certification through the Department of Mental Health. (See also objective on intensive case management.)

In FY 2010, community service providers reported 420 adult services case managers. They provided services to 15,994 adults with serious mental illness (including individuals with Medicaid) through the CMHCs and the Community Services Divisions of MS State Hospital and East MS State Hospital and through private non profit agencies that either received funding or certification through the Department of Mental Health. (See also objective on intensive case management.)

**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

**Was Objective Achieved?** Yes

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**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.

**Comparison/Narrative:**

In FY 2009 and FY 2010, 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. By the end of fiscal year 2009, 100% of the records reviewed for this requirement reflected that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusals placed in writing. No citations were issued in FY 2009 or FY 2010.

**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

**Was Objective Achieved?** Yes

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
CMHCs Funded for Intensive Case Management	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

**Comparison/Narrative:**

In FY 2009, CMHS Block Grant funding for this service was awarded at an approximate 2.8% decrease of the 2006 funding level. All 15 regions received awards ranging from \$35,601.00 to \$39,795.00 each to continue to provide intensive crisis services to those in need. However, due to a decrease in federal funding, each provider had to take a \$1,000.00 across the board cut. These variations in funding levels occurred because providers were given the option to determine which federal (CMHS) program from which to take their portion of the CMHS funding cuts in FY 2006. The current awards range from \$34,601.00 to \$38,795.00. Regions 4 and 8 were also provided additional funds to enhance intensive case management/crisis response services.

In FY 2010, CMHS Block Grant Funding for this service totaled \$586,320, which equated to level funding from FY 2009. The current awards range from \$34,601 to \$79,771. These variations in funding levels occurred because providers were given the option to determine which federal (CMHS) program to take their portion of the CMHS funding cuts in FY 2006. Region 4 was provided additional funds to enhance intensive case management/crisis response services in the northeastern section of the state.

**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

**Was Objective Achieved?** Yes

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**Mental Health Transformation: Involving Consumers Fully in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)**

**Technical Assistance to Case Managers**

**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).

**Comparison/Narrative:**

In FY 2009, four (4) Case Management Task Force meetings were held: in October 2008, January 2009, April 2009, and July 2009. The following topics were discussed: proposed Medicaid State Plan Amendment Update; State of Community Services System Transformation Activities Briefing (by Jake Hutchins, Director, Division of Community Services); In Service: Integrating Consumers into the Workforce: A training that re-introduces the Recovery Model Concept and the benefits of integrating individuals receiving services into the workforce (by the Division of Consumer and Family Affairs Staff, Aurora Baugh, Linda Brown, and Signe Shackelford); Redesigning and Developing Transportation services for Persons living with Disabilities: A statewide approach (by Jan Larson, Global Strategies Inc.); In Service: Does Your Leadership Style Pass The Favoritism Test? (by Thaddeus J. Williams, Division of Community Services); Positive Changes in the Professional Licensure and Certification Programs (by Scott Sumrall, Division of Professional Licensure and Certification); In Service: Completing the Puzzle “Interpreting and Enhancing Differential Diagnosis of Selected Mental Health Disorders” (by Dr. John Norton, Director, Medical Psychiatric Unit University of Mississippi Medical Center, sponsored by Eli Lilly); Discussion: Changes in Targeted Case Management Implications; review of unification effort for case management Services included in DMH Minimum Standards (by Thaddeus J. Williams, Division of Community Services); Review of National Case Management Appreciation Week Celebration Activities.

In FY 2010, four Case Management Task Force meetings were held on the following dates: October 19, 2009; January 19, 2010; April 20, 2010; and July 15, 2010. Technical assistance was provided during these meetings on the following topics: Intensive Case Management Service Delivery Guidelines Revisited allowable and disallowable practices; Update on DMH Strategic Plan/Mental Health Service Delivery System Transformation; In Service: Wrap Around Services-An Overview; Overview of IDD Home & Community Base Waiver Update; 2011 Legislative Session Update: Status of Bills Affecting Mental Health System; Restructuring of Case Management Orientation and Case Management Credentialing Procedures: Recommendations/suggestions for Revising Training Manual, Discussion of Ideas for New Case Management Orientation Process; Discussion of Revised Case Management Credentialing Procedures; and Review/Evaluation of Essential Learning On-Line Training Service.

**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

**Was Objective Achieved?** Yes

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### Case Management Outreach

**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)

### Comparison/Narrative:

In FY 2009, 7,000 brochures were distributed to all providers and at various locations (each year). The 15 CMHCs, the Community Services Divisions of MSH and EMSH, and several private non-profit service agencies received (300 brochures each). The remaining brochures were distributed during Case Management Orientation, the Annual Conference on Homelessness, and local community health fairs, conferences and trainings.

In FY 2010, 7,000 brochures were distributed to all providers and at various locations (each year). The 15 CMHCs, the Community Services Divisions of MSH and EMSH, and several private non-profit service agencies received (300 brochures each). The remaining brochures were distributed during Case Management Orientation, the Annual Conference on Homelessness, and local community health fairs, conferences and trainings and a local church. Expansion of distribution to additional local churches is planned in FY 2011.

### 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

**Was Objective Achieved?** Yes

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**Goal:** To reduce the rate of hospitalization for individuals who are at high risk for re-hospitalization.

**Intensive Residential Treatment Programs**

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Funding – Intensive Residential Programs	3 CMHC Regions	3 CMHC Regions	3 CMHC Regions	7 CMHC Regions 1 DMH Facility

**Comparison/Narrative:**

In FY 2009, the Division of Community Services continued to provide funding for three intensive residential facilities in Regions 6, 13 and 15. These programs are intended to provide immediate care to individuals in acute crisis. In FY 2009 these three programs served a total of 919 individuals.

In FY 2010, the Division of Community Services continued to provide funding for three intensive residential facilities in Region 6, 13, and 15. These programs are intended to provide immediate care to individuals in acute crisis. The intensive residential facility in Region 15 closed after discharging its last resident on August 2, 2010. Region 6 opened a 16-bed intensive residential program September 1, 2009. Region 6 continued to operate both intensive residential programs until February 15, 2010, when admissions to the original five-bed facility ceased. During the 2010 Session, the Legislature approved funding to the Division of Community Services to transfer operations of six more 16-bed

intensive residential facilities. Four additional CMHC regions (Regions 4, 5, 8, 12) (Region 4 operates two facilities) and one DMH facility began operation of these 16-bed intensive residential facilities, funded by the Division of Community Services, which began to take admissions on July 1, 2010. In FY 2010 these ten facilities served a total of 1749 individuals.

**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/re-hospitalization.

**Funding:** State and local funds

**Was Objective Achieved? Yes**

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**Mental Health Transformation Activity: Services for Individuals with Co-occurring Disorders (Mental Illness and Substance Abuse) (NFC Goals 4.3 and 5.3)**

**Objective:** The Co-occurring Disorders Coordinating Committee will continue to meet and make recommendations regarding service delivery and/or training.

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health services

**Brief Name:** Co-occurring Disorders Coordinating Committee Operation

**Indicator:** Continued operation of the Co-occurring Disorders Coordinating Committee, which will focus on strategies for improving services to adults with co-occurring disorders of serious mental illness and substance abuse.

**Measure:** The Co-occurring Disorders Coordinating Committee will continue to meet and report to the MS State Mental Health Planning and Advisory Council on its activities, at least annually.

**Comparison/Narrative:**

In FY 2009, the Co-Occurring Disorders Coordinating Committee met in September, 2009, to review the progress of the consultation, training and clinical coaching initiative begun in FY 2008. As of September, 2009, eight of the 15 regions had received training, which was consistent with the two-year goal to have all 15 regions trained by the end of 2010. Also in FY 2009 the *GAIN Screener* for Co-Occurring disorders was implemented statewide.

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

**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

**Was Objective Achieved?** Yes

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**Objective:** Community-based residential treatment services for individuals with co-occurring disorders will continue in one site.

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Community residential treatment beds for individuals with co-occurring disorders

**Indicator:** Continued operation of a residential treatment service for individuals with co-occurring disorders of serious mental illness and substance abuse.

**Measure:** The number of community residential treatment beds to be made available (12 beds)

PI Data Table A1.16	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Community Residential Dual Diagnosis Beds	12	12 beds; 35 individuals served	12 beds	12 beds; 23 individuals served

**Comparison/Narrative:**

In FY 2009, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 35 individuals in FY 2009.

*Mississippi*

In FY 2010, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 23 individuals in FY 2010.

**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

**Was Objective Achieved?** Yes

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**Objective:** Community services will be provided for individuals with co-occurring disorders in all fifteen mental health regions and by the community services division of one psychiatric hospital.

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Co-occurring disorders - community services availability

**Indicator:** All 15 CMHCs and the community services division of Mississippi State Hospital will provide services to individuals with co-occurring disorders.

**Measure:** The number of individuals with co-occurring disorders to be served (6500)

PI Data Table A1.17	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Served–Dual Diagnosis	8598	9295	6500	10,064

**Comparison/Narrative:**

In FY 2009, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 9295 adults with co-occurring disorders of substance abuse and serious mental illness.

In FY 2010, the 15 CMHCs and Community Services operated by Mississippi State Hospital, East Mississippi State Hospital and Central Mississippi Residential Center reported serving 10,064 adults

with co-occurring disorders of substance abuse and serious mental illness.

**Source(s) of**

**Information:** Adult Services Annual State Plan Survey

**Special**

**Issues:** The number of individuals served does not necessarily remain constant or increase across years, but rather depends on needs identified at the local level.

**Significance:** Individuals with co-occurring disorders of serious mental illness and substance abuse require specialized services to reduce their risk of hospitalization or rehospitalization. Each CMHC must provide specialized co-occurring disorders services as part of the requirements for receiving SAPT funding for dual diagnosis services.

**Funding:** SAPT block grant and state funds

**Was Objective Achieved?** Yes

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**National Outcome Measure: Evidence-Based Practice – Integrated Treatment for Co-Occurring Disorders** (URS Developmental Table 17)

The DMH continued 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, the proposed definition of which is consistent with the approach being disseminated through training efforts in Mississippi in FY 2010, with support from the SAMHSA Transformation Transfer Initiative (TTI). 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 2010, DMH continued work to develop the capacity to collect data on the aggregate total of individuals with co-occurring disorders served in specialized evidence-based programs. Central MS Residential Centers uses the evidenced-based practices materials published by SAMSHA for individuals served in two groups and has incorporated the fidelity measures into their competency training for staff. As noted, training has continued on use of a standard screening instrument for co-occurring disorders, the *Gain Screener*. DMH has continued activities through its Data Infrastructure Grant (DIG) project that included work on the central data repository. These activities have led to the establishment of new codes for reporting of evidence-based practices, including integrated treatment for co-occurring disorders, which will allow for reporting of those services from other providers when they are available and when fidelity is established.

**Family Education/Support and Consumer Education Support Programs**

**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

**Comparison/Narrative:**

In FY 2009, the family education program was made available by NAMI-MS to several CMHC regions across the state. As of September 2009, a total of five Family to Family classes had been conducted in three (3) regions (Regions 2, 9, 15), during which 60 individual family members were served. There were six Family to Family trainers trained. Additionally, 380 support group meetings were held in Regions 2, 3, 4, 6, 9, 10, 13, 14, and 15. There were two Provider Education courses taught this year as well: one at North MS State Hospital and the other at Region 9 Hinds Behavioral Health Center; 44 providers attended. NAMI also offered its Peer to Peer education program, in which nine classes were offered in Regions 5, 6, 9, 10, 13 and at Central Mississippi Regional Center and MS State Hospital, Community Services (Jackson); 55 individuals attended. Additionally, 146 *In Our Own Voice* presentations were made to 3454 attendees. Forty individuals attended the five classes of NAMI Basics: Parent Program in Regions 11, 15, and Cares of Jackson.

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

**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.

**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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Performance Indicator</b>				
Percentage of persons receiving Family Psychoeducation Services*	.12%	.11%	.12%	.13%
Numerator: Number receiving Family Psycho education Services*	64*	60	60	76
Denominator: Number of adults with SMI served (community services)	52,312	53,910	49,000	57,186

\*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.

**Was Objective Achieved? Yes**

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. By mid-year FY 2010, NAMI-MS had trained 24 individuals in two Peer to Peer classes. The target for FY 2010 was modified from 40 to 30 because of the loss of a Peer to Peer Coordinator position and reduced funding. Three Peer to Peer training sessions were scheduled before the end of FY 2010 (July 6-9, 2010, at Beacon Behavioral Health; July 19-22, 2010, at Mississippi State Hospital Community Services; and, a training in Meridian, July 26-29, 2010. The Mississippi Leadership Academy has a training session scheduled for December 2010.

**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)

**Comparison/Narrative:**

In FY 2009, the consumer education training programs were made available to all 15 CMHC regions. The Mississippi Leadership Academy (MLA) conducted one regular training event in December 2008 which produced 18 graduates, and in September 2009, which produced 17 graduates, bringing the total number of MLA graduates to 137. At least 13 of the graduates have assumed lead roles on the MLA planning team. The Director of MLA conducted an in-depth (two-day) Train-the-Trainer Workshop for 13 MLA graduates in February 2009. The newly formed MLA Board consists of 13 MLA graduates, and has met three times during this fiscal year (February, April and October). Thus, the MLA curriculum and classes are now totally supervised by this all-consumer board of officers. The Director of MLA had five MLA graduates as part of the teaching team for the September 2009 class. Future classes will increase the consumer participation in the organizational and teaching aspects of the academy. The goal is to have the academy be completely under the leadership of a statewide consumer coalition executive committee. NAMI also offered its Peer to Peer education program, in which nine classes were offered in Regions 5, 6, 9, 10, 13 and at Central Mississippi Regional Center and MS State Hospital, Community Services (Jackson); 55 individuals attended.

In FY 2010, NAMI offered the Peer to Peer education program; 5 classes were offered in Regions 6, 9, 10, and 14 serving a total of 52 individuals. Central Mississippi Residential Center also served 68 individuals with SAMHSA's Evidence-Based Practice Toolkit on Illness Management and Recovery. No MLA trainings were conducted during FY 2010. The next MLA training is scheduled for December 2010.

**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)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
<b>Mental Health Transformation Performance Indicator</b>				
Percentage of persons served who received illness management/recovery services*	.20	.14	.08	.21**
Numerator: Number Receiving Illness Management/Recovery Services*	103*	73	40	120
Denominator: Number of persons with SMI served (community services)	52,312	53,910	49,000	57,186

\*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).

\*\*Data in FY 2010 also includes one group home program (CMRC) that utilized SAMHSA's Evidence-Based Practices on Illness Management and Recovery.

**Was Objective Achieved? Yes**

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**Other Educational/Support Opportunities**

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system.

**Brief Name:** Availability of consumer educational opportunities

**Indicator:** Continued availability of funding to support educational opportunities for consumers 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 opportunities for consumers to participate in local, state, and/or national trainings and provide educational materials to on self empowerment, recovery, and/or illness management.

**Comparison/Narrative:**

In FY 2009, the Mississippi Mental Health Community Conference was held on May 29-30, 2009, at the Jackson Convention Center in Jackson, MS, and was attended by over 1,300 participants. The conference focused on Mental Health Recovery. Guest speakers included Dr. Dan Fisher, Executive Director of National Empowerment Center, and Mr. Larry Fricks, who currently serves as the Director of the Appalachian Consulting Group and Vice President of Peer Services for the Depression and Bipolar Support Alliance.

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

**Special**

**Issues:** None

**Significance:** Continuing support of local, state or national education/training opportunities. 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

**Was Objective Achieved?** Yes

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**Other Support Groups**

**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 (46 of 71 in 2010) 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 continued support of law enforcement training provided by the CMHCs (in FY 2010) and continued 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).**

<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>				
% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)	52%	69%	64%	65%
Numerator: Number of adult consumers arrested in T1 who	13	75	18	46

were not rearrested in T2 (new and continuing clients combined)				
Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)	25	108	25	71

**Was Objective Achieved?** Yes

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**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 2007 – FY 2010 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above.

**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)**

<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>				
% age of Families of adult consumers reporting positively regarding social connectedness	71%	76%	73%	75%
Numerator: Number of adult consumers reporting positively about social connectedness	447	1112	445	958
Denominator: Total number of adult consumer responses regarding social connectedness	629	1470	607	1,280

**Was Objective Achieved?** Yes

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

**Goal:** To increase satisfaction of adults with serious mental illness regarding their functioning

**Target:** Increase or maintain the percentage of adults with serious mental illness who respond

positively about their functioning

**Population:** Adults with serious mental illness

**Criterion:** Comprehensive, community-based mental health system.

**Indicator:** Percentage of adults with serious mental illness reporting positively regarding functioning.

**Measure:** Percentage of adults with serious mental illness who respond to the survey and who respond positively to items about their functioning on the *MHSIP Consumer Satisfaction Survey*.

**Sources of Information:** Results of the *MHSIP Consumer Satisfaction Survey* from a representative sample of adults with serious mental illness receiving services in the public community mental health system (funded and certified by DMH)

**Special Issues:** Implementing many of the same initiatives aimed at improving outcomes and described in the previous National Outcome Measure on outcomes is projected to also impact individuals' perception of their functioning (described in this National Outcome Measure). These initiatives include activities to provide consumer education and support, to facilitate individuals taking a more active role in their recovery and to disseminate evidence based practices.

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 and 2010 surveys in an effort to increase the response rate to the voluntary survey in individual regions

**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.

<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>				
% age of adult consumers reporting positively regarding functioning	72%	72%	71%	67%
Numerator: Number of adult consumers reporting positively about functioning	456	1053	433	861
Denominator: Total number of adult consumer responses regarding functioning	629	1458	609	1,282

**Was Objective Achieved?** The percentage of adult consumers who reported positively about functioning decreased in FY 2010 from the previous two years and was less than the targeted percentage by 4%. The reasons for this decrease are not apparent from this data, but it is consistent with the decrease in the percentage reporting positively about items in the outcome domain on other items of the satisfaction survey. Activities to improve individuals' functioning will continue to be implemented as described in the FY 2011 State Plan.

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**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 2010. As mentioned previously,

the DMH worked through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other national outcome measures in 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 and FY 2010 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 and FY 2011 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:** Planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization will be continued, as well as initiatives to facilitate the use of evidence-based practices.

**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)	(7)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator					
1. Decreased Rate of Civil Readmissions to state hospitals within 30 days	2.43%	3.5%	4.12%	3.0%	4.1%
Numerator: Number of civil readmissions to any state hospital within 30 days	84	134	175	106	141
Denominator: Total number of civil discharges in the year	3457	3845	4244	3552	3479
2. Decreased Rate of Civil Readmissions to state hospitals within 180 days	12.79%	17.3%	15.62	14.7%	16.7%
Numerator: Number of civil readmissions to any state hospital within 180 days	442	665	663	524	582
Denominator: Total number of civil discharges in the year	3457	3845	4244	3552	3479

**Was Objective Achieved?** The readmission rate within 30 days exceeded the FY 2010 targeted rate by approximately 1%; however, it did not change from FY 2009. The readmission rate within 180 days increased by about 1% from FY 2009 to FY 2010, and it exceeded the targeted rate for FY 2010. The reason(s) for the increase are not readily apparent from this data. Activities to reduce the readmission rates to the state psychiatric hospitals will continue (as described in the FY 2011 State Plan).

**National Outcome Measure: Evidence Based – Number of Practices (Number)**

(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
<b>Performance Indicator</b>	29%	29%	29%	<b>29%</b>
<b>Numerator</b>	2	2	2	<b>2</b>
<b>Denominator</b>	7	7	7	<b>7</b>

**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.

**Comparison/Narrative:** Not an objective in FY 2009; however, the number of evidence-based practices was reported to CMHS upon request.

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

**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), and report from Central Mississippi Residential Center.

**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.

**Was Objective Achieved?** Yes

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**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**

**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.

**Comparison/Narrative:**

In FY 2009 and FY 2010, Mississippi utilized the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the (national) Center for Mental Health Services in the June 24, 1999, issue of the Federal Register, updating estimates using more current population data available from the 2000 U.S. Census. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in 1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the “12-month prevalence is estimated nationally to be 5.4 percent...” As stated in the publication, these estimates are based on noninstitutionalized individuals living in the community. Also, as pointed out

in the discussion of the federal estimation methodology, “only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time.” The definition of serious mental illness among adults in Mississippi, described in the State Plan, falls within the federal definition. As noted in the estimation methodology in the Federal Register, at this time, “...technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence.” The publication also indicated that in the future, “incidence and prevalence data will be collected.”

Estimates in the FY 2009 and FY 2010 State Plans were updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). The estimated number of adults in Mississippi, ages 18 years and above was 2,134,436 based on U.S. Census 2007 population estimates and was 2,155,638 based on U.S. Census 2008 population estimates.

According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 115,260 in 2007 and 5.4% or 116,414 in 2008. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in 1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the “12-month prevalence is estimated nationally to be 5.4 percent...” As stated in the publication, these estimates are based on non institutionalized individuals living in the community. Also, as pointed out in the discussion of the federal estimation methodology, “only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time.” The definition of serious mental illness among adults in Mississippi, described under this criterion, falls within the federal definition.

**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

**Was Objective Achieved? Yes**

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**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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Performance Indicator				
Total persons 18+ years served in public mental health system*	65,145	67,611	62,000	69,134

**Target or Priority Population to be Served Under the State Plan**

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**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)

<b>PI Data Table A2.1</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>	<b>FY 2010 Actual</b>
# Adults with SMI Served	52,312	53,910	49,000	57,186

**Comparison/Narrative:** In FY 2009, a total of 53,910 adults with serious mental illness were served through the public community mental health system, which included 53,636 individuals served by the CMHCs and 274 adults served by the community services divisions of East MS State Hospital, Mississippi State Hospital and Central MS Residential Center.

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

### **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.

**Was Objective Achieved?** Yes

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**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.

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

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

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

**Population:** Adults and children

**Brief Name:** Anti-Stigma Campaign – 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Individuals reached by Anti-stigma campaign	1.3 million reached	900,000 (approximately)	200,000	1.5 million

**Comparison/Narrative:**

In FY 2009, DMH continued to expand its statewide anti-stigma campaign. The anti-stigma committee met four times throughout the year to discuss statewide efforts and to plan for the new anti-stigma campaign which was launched in October 2009. Since Oct. 1, 2008 more than 15,000 anti-stigma brochures were distributed. A majority of these brochures were distributed at Miss. colleges and high schools. Beginning in 2008, DMH combined the anti-stigma campaign efforts with youth suicide prevention efforts. Since October 1, 2008, DMH made more than 75 presentations on the two topics. Speaking engagements included high schools, middle schools, colleges, school counselors and nurses, and teachers and principals. Displays were set up at conferences statewide including the Governor’s Obesity Conference, Jackson State University Mind and Body Fair, Looking to the Future Conference, and the Suicide Prevention Workshop. In January 2009, more than 1,500 students and teachers in Newton County participated in the 3<sup>rd</sup> Annual Mental Health Awareness Day at Central Miss. Residential Ctr. The day focused on presentations about dispelling the stigma associated with mental illness and supporting friends with mental health problems. In May 2009, DMH partnered with MSH and the Rankin County Chamber of Commerce to host the event, “Games Your Children Play” in Rankin County. The conference targeted parents, teachers, caregivers, etc. and discussed issues related to stigma and suicide prevention. More than 90 people attended the event. More than 55 newspaper articles discussing the stigma and suicide prevention were printed statewide since October 1, 2008 reaching more than 900,000 readers. DMH also participated in 12 radio interviews and eight television interviews to discuss stigma.

In FY 2010, in October 2009, DMH and the Mississippi Think Again Network launched the *Think Again* campaign, which is a statewide effort to help people change the way they think about mental health and shatter the silence around suicide. Mississippi’s new anti-stigma campaign focuses on young adults. DMH developed three presentations for parents, students and teachers to coincide with the campaign. DMH also developed a campaign toolkit with press releases, talking points, a letter to the editor template, public service announcements and other items. Since Oct. 1, 2009, a total of 104 *Think Again* and *Shatter the Silence* (anti-stigma/youth suicide prevention) presentations were

conducted statewide, reaching more than 3,200 individuals. During a two-day period, nearly 300 students in the Meridian Public School District participated in the presentations. More than 800 youth who participated in the 4<sup>th</sup> Annual Mental Health Awareness Day in Newton received information about *Think Again*. Information was also presented to more than 350 youth at the Native American Youth Conference, the Hinds County School Counselors, Gulf Coast Counseling Association and others.

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

In October 2009, DMH mailed more than 1,200 informational packets to 6th - 12th grade public school nurses and school counselors in Mississippi. The packets included a letter explaining the *Think Again* and *Shatter the Silence* campaigns and a brochure from each campaign. The letter also offered additional brochures to the schools and presentations to faculty and students. DMH expanded its efforts to the faith-based community by hosting an event at First Baptist Church Gulfport in March 2010. The community event utilized the *Think Again* and *Shatter the Silence* campaigns to educate parents on mental health and youth suicide prevention. By utilizing media coverage and presentations, the *Think Again* campaign reached an audience of 1.5 million.

**Source(s) of**

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

**Special**

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

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

**Funding:** Federal, State and/or local funds

**Was Objective Achieved?** Yes

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**Criterion 3: Children Services (only in Children’s Plan)**

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

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

**Mental Health Transformation Activities: Services for Elderly Persons (NRC Goal 4.4)**

**Local Plans for Services for Elderly Persons**

**Goal:** To provide community mental health and other support services for elderly persons with serious mental illness.

**Objective:** To make available a coordinated local plan for providing services to elderly persons with serious mental illness in all CMHC regions.

**Population:** Adults with Serious Mental Illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Availability of local plans for elderly services

**Indicator:** Availability of a local plan for providing services to elderly persons with serious mental illness.

**Measure:** The number of CMHCs that submit a local plan for providing services to elderly persons with serious mental illness. (Minimum: 15)

PI Data Table A1.6	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Local Plans for Elderly Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

**Comparison/Narrative:**

By September 2009, all 15 CMHCs had submitted local plans for elderly services. The Elderly Task Force met in October of 2008 and August of 2009. In FY 2009, there were 61 elderly psychosocial programs, including 29 elderly psychosocial programs in CMHCs and 32 elderly psychosocial programs in nursing homes in Regions 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, and 15.

In FY 2010, all 15 CMHCs had submitted local plans for elderly services. The Elderly Task Force met in November of 2009 and July of 2010. In FY 2010, there were 87 elderly psychosocial programs, including 32 elderly psychosocial programs in CMHCs

and 55 elderly psychosocial programs in nursing homes in Regions 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, and 15.

**Source(s) of**

**Information:** Community Mental Health Center Local Plans for Elderly Services

**Special**

**Issues:** None

**Significance:** The plans will indicate the services that are provided for elderly persons with mental illness in each region.

**Funding:** Medicaid, state, local, Area Agencies on Aging

**Was Objective Achieved?** Yes

**Elderly Psychosocial Rehabilitation Programs**

**Goal:** To facilitate skills training for staff of elderly psychosocial rehabilitation programs.

**Objective:** To increase the availability of skills training for staff of elderly psychosocial rehabilitation programs.

**Population:** Adults with serious mental illness

**Criterion:** Comprehensive, community-based mental health system

**Brief Name:** Specialized training for elderly services staff

**Indicator:** Provision of training for additional staff in elderly psychosocial rehabilitation programs.

**Measure:** The number of community mental health services staff who complete training for elderly psychosocial rehabilitation programs.

Mental Health Transformation PI Data Table C5.3	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Availability of training for staff in elderly psychosocial rehabilitation programs	Training for 33 staff from elderly psychosocial rehabilitation programs was provided	Training for 20 staff from elderly psychosocial rehabilitation programs was provided	Training for 10 staff from elderly psychosocial rehabilitation programs	Training for 24 staff from elderly psychosocial rehabilitation programs

**Comparison/Narrative:**

In FY 2009, the elderly psychosocial training site in Vicksburg, MS, provided training to eight individuals; the elderly psychosocial program in Hattiesburg, MS, provided training

to eight individuals; and, the elderly psychosocial nursing home training site provided training to four individuals for a total of 20 staff trained in FY 2009. The Division of Community Services provided a one-day workshop “Caring for Our Senior Adults” in Hattiesburg, MS, with over 80 participants attending. A workshop for the northern part of the state is being planned for next year.

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

**Source(s) of**

**Information:** Division of Community Services monthly grant report forms

**Special**

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

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

**Funding:** CMHS Block Grant, local funds

**Was Objective Achieved?** Yes

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Served– Specialized Homeless	913	654	900	1150

**Comparison/Narrative:**

In FY 2009, the five PATH-funded programs served 654 individuals by program as follows: MSH Community Services - 192; EMSH Community Services -133; Gulf Coast Women’s Center - 74; Singing River Services - 48; Mental Health Association of Mississippi - 207. The decrease in numbers reported as served from FY 2008 to FY 2009 reflects a change/correction in reporting parameters: only contacts made with PATH-eligible individuals were reported in FY 2009; in previous years, all contacts with any homeless persons were reported.

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

**Source(s) of**

**Information:** Adult Services State Plan Survey; PATH Grant Annual Report.

**Special**

**Issues:**

The number served in previous years included those enrolled in the PATH program and others who had contact and were provided some assistance, but not enrolled. The results of a needs assessment changed the areas of the state targeted to continue to receive PATH funding for provision of services to individuals with serious mental illness who are homeless. Data will continue to be collected since this reconfiguration of programs.

**Significance:** Specialized outreach and services are needed to identify and address the needs of individuals who are homeless and who also have a serious mental illness, which are often unique and complex.

**Funding:** PATH (if available), local, and state funds

**Was Objective Achieved?** Yes

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Targeted services to rural and homeless populations

**Brief Name:** Gatekeeper workgroup operation and activities

**Indicator:** Continued participation by a DMH staff member on interagency workgroups that identify and/or address the needs of individuals who are homeless.

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

**Comparison/Narrative:**

In FY 2009, DMH staff had participated in the bi-annual National PATH Conference in Alexandria, VA, networking with State PATH contacts from all 50 states, PATH Grant 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 and bi-monthly Partners to End Homelessness committee meetings. MISSIONLinks and Partners to End Homelessness are both groups comprised of area organizations dedicated to serving persons experiencing homelessness.

In FY 2010, a DMH staff member served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area. DMH staff members also attended monthly MISSIONLinks meetings and bi-monthly Partners to End Homelessness committee meetings. MISSIONLinks and Partners to End Homelessness are both groups comprised of area organizations dedicated to serving persons experiencing homelessness. A DMH staff member also attended the SSI/SSDI Outreach Access & Recovery (SOAR) Train-the-Trainer Program offered through SAMHSA. The SOAR program specifically targets easing the application process for SSI/SSDI and increasing the success rates of applications. This program will be extremely useful in helping homeless individuals with serious mental illness receive benefits more quickly, thereby facilitating access to stable housing.

**Source(s) of**

**Information:** Minutes of workgroup meetings and/or Division Activity Reports

**Special**

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

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

**Funding:** State and federal funds

**Was Objective Achieved?** Yes

**Transportation**

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

**Objective:** Transportation services will be made available to facilitate access to mental health services for individuals who lack transportation and live in areas removed from delivery sites.

**Population:** Adults with Serious Mental Illness

**Criterion:** Targeted services to rural and homeless populations

**Brief Name:** Availability of local transportation plans

**Indicator:** Availability of plans by community mental health centers for outreach, including transportation services.

**Measure:** The number of CMHCs that have available local plans that address transportation services (minimum, 15)

PI Data Table A4.2	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Local Plans Addressing Transportation	15 CMHCs	15 CMHCs	15 CMHCs	15 CMHCs

**Comparison/Narrative:**

In FY 2009, all 15 CMHCs submitted community support plans, which were reviewed by the DCS. In FY 2009, 15 CMHCs and the Community Services Divisions of MSH, EMSH and CMRC reported utilizing center-operated vans/other vehicles; 10 CMHCs reported making transportation available through affiliation agreement with other agencies; and, 11 CMHCs and the Community Services Divisions of EMSH, MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

In FY 2010, all 15 CMHCs submitted community support plans, which were reviewed by the Division of Community Services. In FY 2010, 15 CMHCs and the Community Services Divisions of MSH, EMSH and CMRC reported utilizing center-operated vans/other vehicles; 10 CMHCs reported making transportation available through affiliation agreement with other agencies; and, 13 CMHCs and the Community Services Divisions of MSH reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

**Source(s) of Information:** Community support services plan reviews.

**Special Issues:** None

**Significance:** Transportation assistance is needed by some consumers to have access to the services that are available in their communities and/or region.

**Funding:** Local, Section 18 contracts, Section 16b2 purchasing, SSBG, state, and local funds

**Was Objective Achieved?** Yes

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
% Rural Counties with CMHC Office	95%	95%	95%	95%
Numerator: # of rural counties with CMHC office/services*	20	20	20	20
Denominator: # of 100% rural counties in MS	21	21	21	21

\* Typographical error in table from previous reports corrected to match wording of indicator/measure (added “services”), which were not changed.

**Comparison/Narrative:**

In FY 2009 and FY 2010, satellite offices were located or services were available for mental health services in 95% of Mississippi counties designated as 100% rural. Sharkey and Issaquena counties share an office in Rolling Fork, MS (in Sharkey County).

**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

**Was Objective Achieved?** Yes

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**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).**

**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.

**Comparison/Narrative:**

During the 2009 Legislative session, DMH requested the following increases in General State funds for Fiscal Year 2009 for community mental health services for adults: for deficit in Medicaid match on payments made to the regional community mental health centers - \$12,100,000; medication purchase - \$500,000; first year funding of services in the Mississippi Access to Care (MAC) Plan - \$6,537,400. No additional funding was appropriated for the fiscal year that ends June 30, 2009. However, DMH did receive an

additional \$10 million in General funds for the year that ended June 30, 2008, for match on Medicaid payments made to the regional community mental health centers, reducing by almost half the amount that was assessed to the CMHCs to fund the deficit.

Because of the significant financial problems facing the State of Mississippi during the 2009 Legislative Session, the Department of Mental Health limited its requested increase in State General funding to \$24,000,000 to fund the Medicaid match deficit for Medicaid receipts at the 15 regional community mental health centers, and \$1,006,678 to replace an anticipated cut of a like amount in federal Social Services Block Grant (SSBG) funding.

Prior to the “stimulus plan” (American Recovery and Reinvestment Act, or ARRA), Mississippi’s 15 CMHCs were projected to receive approximately \$141 million in Medicaid receipts during the fiscal year that began July 1, 2009. The state share of that was estimated to be \$34 million, and this is the amount that the Division of Medicaid was expected to bill DMH for match. Only \$10 million was expected to be available, though, so DMH asked for an increase of \$24 million to fully fund it. Absent that increase (or some part of it), the 15 mental health centers would, collectively, have been assessed to come up with the \$24 million using a formula that was based primarily on their actual Medicaid receipts (as has been the practice for the last approximately seven years).

Because of ARRA, Mississippi’s share of Medicaid match was reduced from 24.16% to 15.76%. This meant that the state share of \$141 million in Medicaid receipts would be reduced from about \$34 million to about \$22 million, a savings of \$12 million. Under the mistaken belief that the entire match need of \$34 million had been funded, the legislature “swept” \$12 million from DMH’s appropriation. Unfortunately, only \$10 million had been funded, which means that all of the appropriated funds for match were “swept” plus an additional \$2 million. Although DMH has been advising the legislature for years that the match was not fully funded, because of the intensity of the last days of the 2009 session, that simply got overlooked and by the time DMH knew this “sweep” had occurred, it was too late to fix it. (DMH did not have an appropriation until the 2<sup>nd</sup> Extraordinary Session, and the bill that was finally passed was signed by the Governor at 11:51 p.m. on June 30, 2009, the day before the new fiscal year began. DMH did not receive the bill or know the final results until mid-July).

Governor Barbour and key legislators have been made aware of this result and have pledged to do anything that can be done that is also fiscally responsible to address it during the 2010 legislative session. In the meantime, DMH has transferred about \$10 million of funds appropriated to other needs to be used for this Medicaid match. The remaining shortage of \$12 million will be assessed to the mental health centers. Approximate 45% of Medicaid match is for children and youth, and approximately 55% is for adults. In summary, no additional funding was received for Medicaid match and, a 100% cut was received. The anticipated cut to SSBG funding did not occur.

In FY 2010, DMH requested \$30,400,000 for full funding of Medicaid match for the CMHC program in its budget request for the fiscal year that began July 1, 2010; about 45% of these funds address children’s services, the remainder addresses adult services.

No additional funding was appropriated to DMH for the matching funds or any other purpose. CMHC match for FY 2011 will be paid one-half from DMH funds by using money from facility special fund cash balances; the other half will be contributed by the CMHCs.

**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

**Was Objective Achieved?** Yes

**Funding for Services for Persons with Co-occurring Disorders**

**Objective:** To make available through DMH Substance Abuse Prevention and Treatment (SAPT) block grant funds to plan and provide services for individuals with co-occurring disorders (mental health/ substance abuse).

**Population:** Adults with Serious Mental Illness

**Criterion:** Management Systems

**Brief Name:** Availability of funds for services for individuals with co-occurring disorders

**Indicator:** Continued availability of funds through DMH (Substance Abuse Prevention and Treatment Block Grant) to support provision of services to individuals with a co-occurring disorder (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 2008 Target	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
Funding for Dual Diagnosis Services	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions	15 CMHC Regions

**Comparison/Narrative:**

In FY 2009, the DMH allocated \$1,169,132 from SAPT funds to the CMHCs for services to individuals with a co-occurring disorder of mental illness and substance abuse.

DCS also granted \$37,000 to Region 12 to provided statewide training and implementation of the *GAIN Short Screener*.

In FY 2010, the DMH allocated \$1,169,132 from SAPT funds to the CMHCs for services to individuals with a co-occurring disorder of mental illness and substance abuse. In FY 2010, DMH did not allocate funds to provide co-occurring disorders (COD) training to the CMHCs. DMH did receive Transformation Transfer Initiative funding through SAMHSA, which allowed DMH to hire three trainers in the state. The trainers are providing COD training to the remaining CMHC regions. The training consists of three stages: overview of COD, coaching and technical assistance, and evaluation. All regions received training on the *GAIN* screener as part of the COD training and regions continued to use the *GAIN* screener.

**Special**

**Issues:**

As mentioned previously under Criterion 1, the Request for Proposals for applicants (CMHCs) for funding of services for co-occurring disorders was revised to emphasize more specific information on the provision of integrated treatment and staff training.

**Significance:** Availability of funding for services for co-occurring disorder 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

**Was Objective Achieved?** Yes

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**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)

**Comparison/Narrative:**

In FY 2009, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 35 individuals in FY 2009.

In FY 2010, \$238,376 was allocated to the Mississippi State Hospital Division of Community Services in support of a 12-bed community-based residential facility for individuals with a dual diagnosis of substance abuse and serious mental illness, which served 23 individuals in FY 2010.

**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

**Was Objective Achieved?** Yes

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**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**

**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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Case Management Training Sessions	8; 258 case managers trained	7	8	8; 210 case managers trained

**Comparison/Narrative:** In FY 2009, DMH held seven case management orientation sessions (in October 2008; February, March, April, May, and July, 2008, and one session in September 2009). A total of 180 case managers completed case management orientation (Module I) in FY 2009.

In FY 2010, DMH held eight case management orientation sessions (in October 2009; and February, March, April, May, July, September 2-3 and September 16-17, 2010.) A total of 210 case managers completed case management orientation in FY 2010.

**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

**Was Objective Achieved?** Yes

### **Mental Health Therapist Certification and Licensure Program**

**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.

**Comparison/Narrative:**

In FY 2009, a change was made to the application process for individuals applying to move up (upgrade) from provisional certification to full certification that affected both the Mental Health Therapist Program and the Case Management Certification Program. It was decided that applicants would no longer be required to report continuing education hours at both the time of upgrade and the time of renewal. This was determined to be an unnecessary duplication of effort. Rather, we would continue to require continuing education to be addressed at the time of renewal.

In FY 2009, PLACE staff members continued to make application booklets for the Mental Health Therapist Program available upon request; approximately 125 booklets were distributed. By the end of FY 2009, a total of 2,161 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT) or Licensed Clinical Mental Health Therapist (LCMHT).

Also in FY 2009, changes were made to the Mental Health Core Training Program (MH-CTP). The MH-CTP requirement was streamlined from three separate, week-long modules and written examinations to one written Mental Health Therapist examination with self-study as the basic format for test preparation. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009. The content of the remaining one written exam continues to be material outlined by a steering committee made up of community mental health service providers, consumer advocates, consumers/family members, administrators, etc. During FY 2009, the required Mental Health Therapist exam was administered to 146 individuals.

In FY 2009, PLACE staff members continued to make application booklets for the Licensed Mental Health Administrator Program available upon request; approximately 15 booklets were distributed. By the end of FY 2009, the Licensed Mental Health Administrator program included a total of 126 individuals; 25 Program Participants and 101 Licensees. Each Participant continues to receive training in the area of administration through either his/her participation in the Mississippi Certified Public Manager Program or his/her preparation for the required written examinations or his/her participation in DMH's leadership development program called Focus. As of the most recent renewal deadline, December 31, 2007, 68 renewing licensees reported having received the required 40 Contact Hours. The next renewal deadline will be December 31, 2009.

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In FY 2009, PLACE staff continued to offer written exams for the Licensed Mental Health Administrator program. Written examinations were made available to Participants at least one day each month. A total of 2 written examinations were administered to Participants in FY 2009.

In FY 2009, PLACE staff members continued to make application booklets for the Case Management Certification Program available upon request; 26 booklets were distributed. By the end of FY 2009, a total of 758 applications had been received, processed and had resulted in the awarding of professional credentials of Provisionally Certified Case Management Professional (PCCMP), Certified Case Management Professional I (CCMP-I) or Certified Case Management Professional II (CCMP-II).

Also in FY 2009, changes were made to the Case Management Core Training Program (CM-CTP). The CM-CTP requirement was streamlined from three separate modules and written examinations to one required training (Case Management Orientation) and written examination. These changes were made to adopt more current examination practices as well as due to economic factors. With rising travel and training costs, this change has benefited everyone in FY 2009.

In FY 2010, a total of 303 Provisionally Certified Mental Health Therapist (PCMHT), Certified Mental Health Therapist (CMHT), or Licensed Mental Health Therapist (LCMHT) credentials were awarded. The Mental Health Therapist credentialing exam was administered to 110 individuals seeking certification.

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

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

**Source(s) of**

**Information:** DMH/PLACE database; PLACE staff

**Special Issues:** None

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

**Funding:** State funds

**Was Objective Achieved?** Yes

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 2007–FY 2008 and actual numbers for FY 2009 – FY 2010 are indicated in the chart that follows:

Credentialing Program	FY 2007 (Actual)	FY 2008 (Actual)	FY 2009 (Actual)	FY 2010 (Target)	FY 2010 (Actual)
Mental Health Therapists (all levels)	1,733	1,959	2,161	2,175	2,237
Mental Health Administrators (all levels)	121	122	126	125	127
Number of individuals in the Case Management Certification Program (Beginning FY 2006)	367	629	758	845	844

**Academic Linkages at the Local Level** continued in FY 2010, with CMHCs and the Community Services Divisions at East Mississippi State Hospital, Mississippi State Hospital and Central Mississippi Residential Center 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, counseling education, school counseling, sociology/criminal justice, rehabilitation counseling, education, family and human development, public policy and administration, nursing, family studies, nurse practitioners, counseling social work, counseling psychology, Center for Civic Engagement and Social Responsibility program at a private college, a Faith and Work Initiative at a private college, nursing, marriage and family counseling, 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). Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. 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 toward the end of 2008 for two community mental health centers (in Greenwood and in Clarksdale). They have expanded this service across the Delta region and expect to have all the community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service has set up a telepsychiatry unit based 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 is also using 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 received additional funding from the Delta Health Alliance during FY 2010 to expand services to satellite sites in the Delta Region (in CMHC Regions 1 and 6) and to expand training opportunities for staff. 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**

**Objective:** Training for CMHC staff in providing pre-evaluation screening for individuals being considered for civil commitment will be made available.

**Population:** Adults with Serious Mental Illness

**Criterion:** Management Systems

**Brief Name:** Pre-evaluation screener training

**Indicator:** Availability of training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Minimum Standards.

**Measure:** The number of training sessions in pre-evaluation screening made available by DMH (minimum of four).

PI Data Table A5.3	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual
# Pre-evaluation Screening Training Sessions	6	6	4	6

**Comparison/Narrative:**

In FY 2009, consumers and family members shared their perspectives of going through the pre-evaluation screening process with CMHC staff being trained. New staff from DMH, Mental Health Association of the Capital Area and the Mental Health Association of Mississippi also attended the training. There were 6 sessions in which 95 individuals were trained.

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

**Source(s) of Information:** DMH Training Records

**Special Issues:** None

**Significance:** The pre-evaluation training is designed to increase uniformity in procedure and to better ensure minimum competence level of staff who conduct screening. This training should enhance the information provided to the court and facilitate communication between

mental health providers, consumers and families, and the court system.

**Funding:** State funds

**Was Objective Achieved?** Yes

**Training of Emergency Health Workers in the Area of Mental Health**

**Mental Health Transformation Activity: Improving Coordination of Care among Multiple Systems**

**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 Actual	FY 2010 Actual
# 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	Funding made available to 15 CMHC regions; 12 regions participated; 42 sessions provided; 1443 officers trained	Funding made available to 15 CMHC regions; 12 regions participated; 24 sessions provided; 365 officers trained

**Comparison/Narrative:**

In FY 2009, DMH made funding available to 15 community mental health center regions for support of the provision of law enforcement training; 12 regions applied for and received the funding. A total of 42 training sessions were conducted, with 1,443 law enforcement officers trained throughout the state.

In FY 2010, DMH made funding available to 15 community mental health centers for

support of the provision of law enforcement training; 12 regions applied for and received the funding. A total of 24 training sessions were conducted, with 365 law enforcement officers trained throughout the state.

**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

**Was Objective Achieved?** Yes

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**Information Management Systems Development**

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

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Management Systems

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

**Indicators/Strategies:**

- A) Work will continue to coordinate the further development and maintenance of uniform data reporting and further development and maintenance of uniform data standards across service providers. Projected activities may include, but are not limited to:
- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the 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.

**Comparison/Narrative:**

In FY 2009, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data need to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Thirteen out of 15, or 87%, of regional community mental health centers (CMHCs) and two out of four, or 50%, of the state psychiatric hospitals are presently submitting data that populates the database.

The Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and we are about to embark on the task of setting up the Children's non-profits so they may enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables but we hope to have that task completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

The Manual of Uniform Data Standards is still in draft form as we continue work on the CDR.

Our continued approach has been to address collection, software upgrades, reporting quality, and training issues pertaining to the data at the local level, to bring all data from administrative sources into the central data repository by file upload and browser based data entry, to provide for monitoring of the data for accuracy and timeliness by Central Office personnel and to report the data to the CMHS in the form of the URS tables and in the State Plan as National Outcome Measures as required.

Ongoing technical assistance and training is also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training is also planned to facilitate communication among stakeholders.

In FY 2010, MDMH continued to work closely with the Mississippi Department of Information Technology Services (ITS) and service providers in the further development and advancement of the central data repository. MDMH also continues to work with Boston Technologies, Inc. (BTI) and other software vendors to make changes necessary for service providers to capture and report the data needed to populate the CDR.

The Mississippi Department of Mental Health now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. All fifteen regional community mental health centers and three out of four of the state psychiatric hospitals are presently submitting data that populates the database.

The 13 Alcohol and Drugs non-profit programs are also submitting data to populate the CDR and MIS staff are embarking on work to enable the children's non-profit programs to enter data into CDR.

A report of error totals can be viewed by the reporting organization via a web page. The reporting organization can also download a detailed error file via a web page using https. Reporting of URS tables to a web page is still in the testing stage for some tables; the task is projected to be completed by next year. The centralized database is stored on a MS SQL database. Social security number and name are encrypted using Advanced Encryption Standard (AES).

The Manual of Uniform Data Standards is still in draft form as DMH continues work on the CDR.

DMH MIS has continued its approach to address collection, software upgrades, reporting quality, and training issues pertaining to the data at the local level, to bring all data from administrative sources into the central data repository by file upload and browser based data entry, to provide for monitoring of the data for accuracy and timeliness by Central Office personnel and to report the data to the CMHS in the form of the URS tables and in the State Plan as National Outcome Measures as required.

Ongoing technical assistance and training are also needed to address the limited information management staff available at the local level at most provider organizations. Increased education and training of staff at the local level and Central Office personnel training are also planned to facilitate communication among stakeholders.

**Source(s) of**

**Information:** Users Group meeting minutes; DIG grant reports

**Special**

**Issues:** As previously indicated, the DMH has received a Data Infrastructure Grant from the Center for Mental Health Services to address the core set of data specified by CMHS and to be reported as part of the State Plan Implementation Reporting process. The primary goal of this grant is to facilitate ongoing efforts of the DMH to implement a collection of planning-related data, including National Outcome Measures for the CMHS Block Grant, from the community mental health providers it funds/certifies.

**Significance:** Availability and accessibility of additional current data about the implementation of community mental health services will greatly enhance program evaluation and planning efforts at the state and local levels.

**Funding:** State funds, Federal funds

**Was Objective Achieved? Yes**

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**FY 2010 CMHS Block Grant Projected Expenditures  
by Type of Service for Adults with Serious Mental Illness**

<b><u>Service</u></b>	<b><u>Projected Est. Expend.</u></b>
Individual Therapy	\$353,761
Medication Evaluation/Monitoring	\$79,523
Family Therapy	\$3,804
Group Therapy	\$26,283
Psychosocial Rehabilitation/Employment Enhancement	\$612,620
Nursing Services	\$43,340
IM/SC Administration of Psychotropic Medication	\$1,558
Case Management /ICM	\$754,830
Emergency	\$34,264
Community Residential	\$34,822
Consumer Education	\$112,211
Family Education/Support	\$68,751
Peer Review/Technical Assistance	\$31,617
Drop-in Centers	\$69,660
Adult Making A Plan (AMAP) Teams	\$29,315
Transportation pilot program	<u>\$10,870</u>
<b>TOTAL</b>	<b>\$2,205,211</b>

**Projected Expenditures of FY 2010 CMHS Block Grant  
Funds for Adult Services by Region/Provider**

<b>Provider</b>	<b>Projected Expenditures</b>
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	\$131,843.14
Delta Community Mental Health Services P.O. Box 5365 Greenville, MS 38704-5365 Richard Duggin Interim Executive Director	\$121,818.00
Life Help P.O. Box 1505 Greenwood, MS 38930 Madolyn Smith, Executive Director	\$146,453.00
Community Counseling Services P.O. Box 1188 Starkville, MS 39759 Jackie Edwards, Executive Director	\$130,475.00*
Region 8 Mental Health Services P.O. Box 88 Brandon, MS 39043 Dave Van, Executive Director	\$134,349.00*

*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	\$101,484.14
Warren-Yazoo Mental Health Services P.O. Box 820691 Vicksburg, MS 39182 Steve Roark, Executive Director	\$92,885.14
Mental Health America of Central Mississippi 407 Briarwood Drive - Suite 208 Jackson, MS 39206 Debbie Holt, Executive Director	\$ 3,405.17
NAMI-MS 411 Briarwood Drive - Suite 401 Jackson, MS 39206 Tonya Tate, 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

\$69,660.00

MS Department of Mental Health  
1101 Robert E. Lee Building  
239 North Lamar Street  
Jackson, MS 39201  
Edwin C. LeGrand III, Executive Director

One Resource Center  
710 Bradley Road  
Corinth, MS 38834

\$ 8,420.00

Funds to support consumer and family education/training opportunities  
at annual state conference, as well as other local, state or  
national education/training opportunities

\$112,211.83

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)

\$32,376.52

Funds to support pilot transportation project

\$10,870

**Total**

\$2,205,211

**Note:** A total of \$187,722 (5% of the total award to be spent on services in FY 2010) is projected to be used by the Mississippi Department of Mental Health for administration. It is projected that \$103,491 will be spent for administrative expenses related to adult community mental health services.