Dr. Hank Bounds, Commissioner  
Mississippi Board of Trustees of State Institutions of Higher Learning  
3825 Ridgewood Road  
Jackson, MS  39211  

Dear Dr. Bounds:  

Attached is a copy of the draft of the FY 2012-2013 MS State Plan for Community Mental Health Services. Also attached is a draft of the FY 2012-2013 MS Department of Mental Health, State Plan for Alcohol and Drug Abuse Services. As in previous years, we are asking your cooperation in making the draft plans available to all interested persons in your organization and community. Various newspapers across the state have published public notice of the availability of the draft plans for public review and comment from July 11, 2011 – August 9, 2011, at the 15 regional community mental health centers, four state psychiatric hospitals, five regional centers for persons with intellectual/developmental disabilities, the Central MS Residential Center, the Mississippi Adolescent Center, the Specialized Treatment Facility and the DMH website. Information regarding submission of comments to the plans is included in the “Forward” of the enclosed draft mental health plan and in the “Purpose” section of the substance abuse services plan. As noted, because of changes in federal guidance for plan development that are still not final, additional modifications to objectives in the draft plans may be required.  

We also welcome your comments and input to the enclosed drafts. As indicated in the plans, comments to the current draft plans submitted by August 9, 2011, will be considered. Since the plans are working documents, however, comments from consumers, family members, service providers and other interested individuals and groups are requested throughout the planning process during the year. Comments received after August 9, 2011, will be considered as work on the FY 2014 plans continues.  

Thank you for your help in facilitating public input to the enclosed MS Department of Mental Health services plans. Please direct individuals with questions to me (Tessie Smith) in the Division of Planning, at the above address/telephone number, or to my email address:  
tessie.smith@dmh.state.ms.us.  

Sincerely,  

Teresa A. Smith, Director  
Division of Planning, Bureau of Community Services  

Attachments  

cc: Mr. Edwin C. LeGrand III  
Mr. Matt Armstrong  
Mr. Herbert Loving
FOREWORD

The Draft Fiscal Years 2011-2012-2013 Mississippi State Plan for Community Mental Health Services was developed by staff of the Mississippi Department of Mental Health, in collaboration with the Mississippi State Mental Health Planning and Advisory Council. The Council serves in an advisory capacity to the Department in identifying service needs, in updating annual objectives to meet those needs, and in reviewing and monitoring progress on implementation of objectives throughout the year. The Mississippi Department of Mental Health greatly appreciates the commitment and work of Council members, and primary consumers from across the state. Their contributions to the ongoing planning process are key to continued progress in improving availability and accessibility of services for adults with serious mental illness and children with serious emotional disturbance. This State Plan document represents the cumulative long-range planning efforts of the Council and the Department of Mental Health in setting forth and pursuing a vision for an ideal comprehensive system of community mental health services for children with serious emotional disturbance and adults with serious mental illness in Mississippi. The Plan also addresses criteria for state plans included in federal law, as required for the state’s application for Center for Mental Health Services Block Grant funds.

The purpose of the State Plan for Community Mental Health Services is to describe the comprehensive, community-based service delivery system for individuals with mental illness upon which program planning and development are based, to set forth annual goals/objectives to address identified needs, to assist the public in understanding efforts employed and planned by the Department of Mental Health to provide supports to Mississippi’s citizens with mental illness and serious emotional disturbance, to serve as a basis for utilization of federal, state and other available resources, and to provide, through the Mississippi State Planning and Advisory Council, an avenue for individuals, family members, and service providers to work together in identifying and planning an array of services and supports through the annual update of this Plan.

A Note About Funding: The draft plan reflects projected use of CMHS Block Grant funds in FY 2011-2012-2013, including the decrease in FY 2009-2010 (current year) CMHS Block Grant funds. The Draft FY 2011-2012-2013 State Plan also includes objectives related to projected use of state funds, as well as use of other resources for community mental health services. Included under Criterion #5 in the Children’s Plan and under Criterion #5 in the Adult Plan are objectives to request additional state funds for the 2011-2012 fiscal year. Changes indicated under these criteria also

A Note About Format and Possible Revisions: The Draft FY 2012-2013 State Plan was developed under draft guidance and application instructions provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). Many of the changes in the draft Plan from the previous year are related to this new draft guidance.
Additional revisions to the draft plan, including changes in content and format, may be made to address ongoing input from stakeholders and additional clarifying instructions from SAMHSA and final federal guidance and instructions, the publication of which is anticipated some time in the summer 2011. The process to make the draft Plan available for input in its current format is proceeding to allow sufficient time for public review and comments and compliance with federal submission timelines.

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

The Mississippi State Mental Health Planning and Advisory Council
c/o Division of Planning, Bureau of Community Services
Mississippi Department of Mental Health
239 North Lamar Street, 1101 Robert E. Lee Building
Jackson, MS 39201

Telephone: (601) 359-1288
TDD: (601) 359-6230
FAX: (601) 359-6295.
e-mail: tessie.smith@dmh.state.ms.us

Comments to the Draft FY 2011 2012-2013 State Plan received after the comment period (July 3, August 1, 2009) (July 11 – August 9, 2011) will be considered in development of the FY 2012 2014 Plan.
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I. Description of the State Service System
(To be updated)

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

The 1990 U. S. Census indicated that in 1989, 20.2% of Mississippi families lived below the poverty level. According to the 2000 U.S. Census, in 1999, 19.9% of individuals in Mississippi lived below the poverty level, and 16% of Mississippi families lived below the poverty level. The 2000 Census also indicated that 22.2% of families with related children under 18 years of age lived below the poverty level in 1999. Over the last decade, Mississippi has shown increases in income and signs of decreasing unemployment. The per capita income of Mississippi in 1991 was reported to be $13,328, which was 69.8% of the national average (Handbook of Selected Data, 1993); however, based on the 2000 U.S. Census, per capita income had risen to $15,853. In 1991, unemployment was 8.6% (Handbook of Selected Data, 1993). The moving 12-month average unemployment rate for the state as of April 2010 was 10.4%, with the number of unemployed averaging 135,200 and the number of employed (excluding the military) averaging 1,158,800. (The national average unemployment rate for the month of April 2010 was 9.7%. Mississippi Department of Employment Security, May 2009).

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

The State Public Mental Health Service System

The public mental health system in Mississippi is administered by the Mississippi Department of Mental Health, which was created in 1974 by an act of the Mississippi Legislature, Regular Session.

Organizational Structure of the Mississippi Department of Mental Health

The structure of the DMH is composed of three interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-operated facilities and community services programs.

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

DMH Central Office – The Executive Director directs all administrative functions and implements policies established by the State Board of Mental Health. DMH has a state Central Office for administrative, monitoring, and service areas. The Division of Legal Services, the Office of Constituency Services, the Director of Public Information, and the Director of Disaster Preparedness and Response report directly to the Executive Director. 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. 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.
DMH has seven bureaus: Administration, the Mental Health, Community Mental Health Services, Alcohol and Drug Abuse Services, Intellectual and Developmental Disabilities, the Interdisciplinary Programs, and Workforce Development and Training.

**The Bureau of Administration** works in concert with all Bureaus to administer and support development and administration of mental health services in the state. The Bureau of Administration provides three major services, including accounting, auditing and information/data management. The Division of Information Systems (which provides support to the Bureau of Mental Health, the Bureau of Community Services and its service provider network in data management is part of the Bureau. The Bureau of Administration includes the following divisions: Accounting, Audit and Grants Management, and Information Systems.

**The Bureau of Community Mental Health Services** has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer’s disease/other dementia. The Bureau of Community Mental Health Services provides a variety of services through the following divisions: Accreditation and Licensure, Mental Health Community Services (for Adults), Children and Youth Services, Alzheimer’s Disease and Other Dementia, Planning, and Consumer and Family Affairs. The Division of Planning provides administrative support to the Mental Health Planning and Advisory Council and supports Bureau of Community Services staff in developing the State Plan and other planning, training and research activities. For example, the Division oversees the provision of pre-evaluation screening training and is working to address the development of a strategic plan for housing. The Division of Accreditation and Licensure for Mental Health is responsible for coordination and development of minimum operational standards for community programs that receive funds through the authority of the Department of Mental Health, as well as the coordination of review, monitoring, and certification processes to ensure that all community programs meet those operational standards. The Division works with staff of other service divisions in the Central Office to implement this ongoing program monitoring process. Objectives of other service divisions are described in the text of the State Plans.

**The Bureau of Alcohol and Drug Abuse Services** is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems, including state Three-Percent Alcohol Tax funds for DMH. The overall goal of the state's substance abuse service system is to provide a continuum of community-based, accessible services, including prevention, outpatient, detoxification, community-based primary and transitional residential treatment, inpatient and aftercare services. Community-based alcohol/drug abuse services are provided through the regional community mental health centers, state agencies, and other nonprofit programs. The Bureau includes the Division of Prevention Services and the Division of Treatment Services.
Mississippi

The Bureau of Mental Health oversees the six state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services as well as the Central Mississippi Residential Center and the Specialized Treatment Facility, a specialized treatment facility for youth with emotional disturbances whose behavior requires specialized treatment.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for individuals in the state with intellectual and developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive regional centers for individuals with intellectual and developmental disabilities, one juvenile rehabilitation center for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services. The Bureau of IDD includes the Division of Home and Community-Based (HCBS) ID/DD Waiver and the Division of Early Intervention Services.

The Bureau of Interdisciplinary Programs works with all other DMH programmatic bureaus, DMH facilities, and DMH-certified programs. The Bureau of Interdisciplinary Programs facilitates and coordinates the collection of information to develop reports, formulate policies, and develop rules and regulations as necessary for the Board of Mental Health and Executive Director; develops strategies for project management and organization; and, completes special projects for the Board of Mental Health and DMH. The Bureau Director of Interdisciplinary Programs serves as the liaison to the Board of Mental Health, and provides administrative leadership in the planning, directing, and coordinating of the Board of Mental Health and DMH Strategic Plan.

The Bureau of Workforce Development and Training advises the Executive Director and State Board of Mental Health on the human resource and training needs of the agency, assists in educating the Legislature as to budget needs, oversees the leadership development program, and serves as liaison for DMH facilities to the State Personnel Board. This Bureau includes the Division of Professional Development and the Division of Professional Licensure and Certification.

The Division of Constituency Services is responsible for the documentation, investigation and resolution of all complaints/grievances regarding state and community mental health/mental retardation facilities that are received from individuals receiving services, family members and the general public.

The Division of Disaster Preparedness and Response, which carries out MDMH’s responsibilities as outlined in the Mississippi Comprehensive Emergency Management Plan, refines DMH’s statewide disaster response system and creates and maintains the agency’s disaster response plan. This division assists the DMH-operated facilities and local community mental health centers with disaster preparedness and response efforts.
Administration of Community-Based Mental Health Services

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set minimum operational standards for the operation of those services it funds, and to monitor compliance with those minimum operational standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies. As described throughout the State Plan, the MS Department of Mental Health is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in and/or facilitates numerous avenues for ongoing communication with consumers, family members and services providers, such as the MS State Mental Health Planning and Advisory Council; the Regional Commissions Group, members of which include the governing boards or commissions of community mental health centers; and, various task forces and committees that engage in ongoing efforts to improve the service system (described in the State Plan).

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

As mentioned above, The MS Department of Mental Health is under separate governance by the State Board of Mental Health, but oversees mental health, intellectual/developmental disabilities, and substance abuse services, as well as limited services for persons with Alzheimer’s disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role (described previously); however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan.

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

In Mississippi, coordination of services is a cooperative effort across major service agencies I provision of the System of Care. Responsible state agencies are as follows:

Division of Medicaid, Office of the Governor (lead agency)

(To be updated)

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 Operational Standards also require that residential programs for children with serious emotional disturbance have in place plans for providing medical and dental services.

Mississippi Health Benefits is a cumulative term for the programs available for uninsured children. These include traditional Medicaid and the Children’s Health Insurance
Mississippi

The same application is used by individuals to apply for Mississippi Medicaid and CHIP. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP.

Applications and redeterminations can be made at the 30 Regional Medicaid Offices, as well as additional outstation locations. Outstation locations include: local health departments, hospitals, and Federally Qualified Health Centers.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for a Community-based Alternatives Psychiatric Residential Treatment Facilities (CA-PRTF) program, one of 10 PRTF Demonstration Projects approved that year by the federal Centers for Medicare and Medicaid Services (CMS). The name of the program is Mississippi Youth Programs Around the Clock (MYPAC). Funds from this grant will assist Mississippi in developing home- and community-based alternatives to residential treatment or institutionalization and significantly assist Mississippi in further developing and implementing a strong infrastructure, particularly for the one to three percent of the population with the most intensive needs targeted. The maximum unduplicated count of youth to be served through the program over the five-year project will be 1970. Programs approved for funding under this demonstration grant will include 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and wrap around teams that will develop individual service plans. Mississippi Medicaid’s resulting research data will be evaluated for cost effectiveness, quality of treatment, and outcomes for the children involved. The CA-PRTF demonstration grant, which will be administered by the Mental Health Programs Bureau, Division of Special Mental Health Initiatives within the Division of Medicaid, will only operate as a waiver and will compare cost of PRTF care to the cost of the waiver. The amount of the grant, which is $49 million, is to be dispersed over a five-year period and can only be used for the expenses incurred by this waiver program. The outcomes from the MYPAC program are expected to be shorter lengths of stay at PRTFs, a decrease in PRTF beds over time, more coordinated treatment for youth with SED, a reduction in the overall cost to the State, and an improved system of care for youth with SED.

The Department of Mental Health is continuing to work with the Division of Medicaid to develop a proposed State Plan Amendment and/or a waiver for submission to the Center for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community based services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Bureau of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults. In February, the MS Division of Medicaid was one of 13 states that was awarded Money Follows the Person demonstration grants. MS received $37 million over the next six years. The DMH has worked closely with the Division of Medicaid to assist in this effort. We anticipate this demonstration will increase the use of home and community based services and reduce the use of institutionally-based services. This will help to eliminate barriers that prevent or restrict flexible use of Medicaid funds and will enable individuals to receive long-term care in the setting of their choice. The state expects approximately 595 individuals will be
transitioned from institutions to the community over the six year demonstration project.

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

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

Social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (DHS) for families/children who meet eligibility criteria for those specific programs. The DHS Division of Family and Children’s Services provides child protective services, child abuse/neglect prevention, family preservation/support, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The DHS Division of Family and Children’s Services and the Division of Youth Services work closely with the Department of Mental Health through participation on the MS State Mental Health Planning Council, MAP teams and other committees. The DHS Division of Economic Assistance provides Temporary Assistance for Needy Families (TANF), TANF Work Program, Health Marriage Initiative, Supplemental Nutrition Assistance Program (SNAP), the Emergency Food Assistance Program (TEFAP), SNAP Nutrition Education, and the “Just Wait” Abstinence Education program. The DHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, and oversees the state training schools. The DHS Division of Child Support provides child support location/enforcement services, and non-custodial visitation programs. The DHS Division of Children and Youth provides certificates for child care services for TANF clients, child welfare clients and some working foster parents. The DHS Division of Aging and Adult Services (DAAS) plans, advocates for, and coordinates the delivery of services to adults 60 years of age and older through a system of local Area Agencies on Aging (AAAs). The DAAS’s goal is to provide support services to help people remain in their own homes and local communities. The DAAS developed a single point of entry system for the aged and adult population with disabilities: the Aging and Disability Resource Center, called Mississippi Get Help. The project was piloted in central Mississippi and is scheduled to expand statewide with a toll-free, telephonic, virtual web-based, and face-to-face resource center that provides access to information, as well as assistance in applying for services. The “no wrong door” approach assures the public consistent information and assistance. In addition, it helps the public navigate through what can seem like a maze of government assistance, as well as the private and nonprofit service system. The Division of Aging and Adult Services also investigates abuse, neglect and exploitation of vulnerable adults, ages 18 and older in private settings under the Adult Protective Services program. The DHS Division of Community Services provides services such as the Fatherhood initiative, homeless resource referrals and low income utility assistance.
Mississippi

Additional social services and financial assistance are accessed as needed for adults with serious mental illness and are administered through various public service agencies/organizations, such as the MS Department of Human Services (described above), the Division of Medicaid, the Department of Health, the Social Security Administration, the Cooperative Extension Service, the Salvation Army, churches, etc. Examples of this assistance include SNAP benefits, medical/other financial assistance, nutrition services, protective services, transportation, financial counseling, etc.

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

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

*To be updated*

Children with serious emotional disturbance who meet eligibility criteria in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state.

In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning. One community residential program for youth with substance abuse problems, The ARK, in Jackson, MS provides a State Department of Education accredited special school on campus. Two approved Department of Education teacher units are provided at Sunflower Landing, another community residential program for adolescents with substance abuse problems. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems.

A free appropriate public education (FAPE) must be available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP).

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

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

*(To be updated)*

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

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 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.
Mississippi

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.

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

Outpatient health and medical care is also available through federally funded Community Health Centers in the state. There are 21 Community Health Centers, with over 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, and provide services in a linguistically and culturally appropriate manner. 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 40% of health center adult 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 nationally. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration’s Bureau of Primary Health Care, fulfilling President Obama’s Growth Initiative for Community Health Centers. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

The MS Department of Health (MSDH) also makes available certain specialized health care programs, such as: Home Care Services for homebound individuals requiring intermittent professional health services while under a physician’s care; WIC, the Special Supplemental Nutrition Program for Women, Infants and Children; the Breast and Cervical Cancer Early Detection Program, offering screening to uninsured, underinsured and minority women within specified age ranges for screening; the Domestic Violence/Rape Prevention and Crisis Intervention Program, providing resources through contracts with domestic violence shelters and rape crisis programs,
Mississippi

including educational resources; the Family Planning Program; Maternity Services; targeting pregnant women whose income is below 185 of poverty and including special initiatives such as the Perinatal High Risk Management/Infant Services System and the Pregnancy Risk Assessment Monitoring System (PRAMS). Through other internal programs and community initiatives, MSDH works to address issues such as teen pregnancy, tobacco use, and unintentional injuries, and to promote specific interventions to decrease infant mortality.

Rehabilitation Services: Mississippi Department of Rehabilitation Services

(To be updated)
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 2009 included: independent living skills training, occupational therapy and development, GED programs, job training and placement, interviewing training, life skills assessment, supported employment, job coaching, , work readiness programs, basic technical skills training, resume and application assistance, and technology training. These services were provided through a variety of state and local resources and providers, which can vary across communities, such as: Job Corps, the Mississippi State Employment Security Commission, WIN Job Centers, the Mississippi Department of Rehabilitation Services, local school districts, Allied Enterprises, Recruitment/Training Program of Mississippi, PRCC, local nonprofit organizations, local businesses, Community Action Agency, a private college career center, Ability Works of Mississippi, county vocational-technical
centers, Youth Challenge Program, the Mississippi Department of Human Services, MIDD, MIDD West Industries, Pine Belt Mental Healthcare Resources Transitional Outreach Program, Pine Belt Graphics, PALS, Youth Challenge, Jackson State University, and community colleges.

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

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

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

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

Description of Regional Resources

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

Regional community mental health/mental retardation centers operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 15 regional centers make available a range
of community-based mental health services, as well as substance abuse and intellectual/developmental disabilities services to all 82 counties in Mississippi. (See maps and list of community mental health centers on the next pages.) The governing authorities are considered regional and not state-level entities. The Mississippi Department of Mental Health is responsible for certifying, monitoring, and assisting the regional community mental health centers. These regional community mental health centers are the primary service providers with whom the Department of Mental Health contracts to provide community-based services. In addition to state and federal funds, these centers receive county tax funds and generate funds through sliding fees for services, third party payments, including Medicaid, grants from other agencies such as the United Way, service contracts, and donations.

Generally, community mental health centers have the first option to contract to provide mental health services within their regions when funds are available. The same regional commission legislation that provides for the structure of the community-based regional (multi-county) commissions also authorized participating counties to levy up to two mills tax for programs designed by the regional commission. As a result of this, county tax money preceded state money in the community mental health programs throughout the state. Rather than assess a specific tax, however, counties now make contributions for mental health services from their general tax assessment. The Department of Mental Health is prohibited from funding services at any regional community mental health center that does not receive a specified minimum level of support from each county in the region. That minimum level is the greater of (1) the proceeds of a ¾ mill tax in 1982 or (2) the actual contribution made in 1984.

All counties were in compliance with this provision for 2009; the total received from all counties is approximately 3% of total community mental health center receipts. During the last few years, the community mental health centers have made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers.
| Region 1: Coahoma, Quitman, Tallahatchie, Tunica | Region One Mental Health Center  
Karen Corley, Interim Executive Director  
1742 Cheryl Street  
P. O. Box 1046  
Clarksdale, MS 38614  
(662) 627-7267 |
| --- | --- |
| Region 2: Calhoun, "* DeSoto*, Lafayette, Marshall, Panola, Tate, Yalobusha  
*Change effective October 1, 2010 | Communicare  
Carole B. Haney, Acting Executive Director  
Sandy Rogers, Ph.D., Executive Director  
152 Highway 7 South  
Oxford, MS 38655  
(662) 234-7521 |
| Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union | Region III Mental Health Center  
Robert Smith, Executive Director  
2434 South Eason Boulevard  
Tupelo, MS 38801  
(662) 844-1717 |
| Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto*  
*Change effective October 1, 2010 | Timber Hills Mental Health Services  
Charlie D. Spearman, Sr., Executive Director  
303 N. Madison St.  
P. O. Box 839  
Corinth, MS 38835-0839  
(662) 286-9883 |
| Region 5: Bolivar, Issaquena, Sharkey, Washington | Delta Community Mental Health Services  
Richard Duggin, Executive Director  
1654 East Union Street  
P. O. Box 5365  
Greenville, MS 38704-5365  
(662) 335-5274 |
| Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower | Life Help  
Madelyn Smith, Executive Director  
Browning Road  
P. O. Box 1505  
Greenwood, MS 38935-1505  
(662) 453-6211 |
| Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston | Community Counseling Services  
Jackie Edwards, Executive Director  
302 North Jackson Street  
P. O. Box 1188  
Starkville, MS 39760-1188  
(662) 323-9261 |
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<tr>
<th>Region 8:</th>
<th>Region 8 Mental Health Services</th>
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<tbody>
<tr>
<td>Copiah, Madison,</td>
<td>Dave Van, Executive Director</td>
<td></td>
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<tr>
<td>Rankin, Simpson,</td>
<td>613 Marquette Road</td>
<td></td>
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<tr>
<td>Lincoln*</td>
<td>P. O. Box 88</td>
<td></td>
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<tr>
<td>*Change effective</td>
<td>Brandon, MS 39043 (601) 825-8800 (Service);</td>
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<tr>
<td>October 1, 2010</td>
<td>(601) 824-0342 (Admin.)</td>
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<tr>
<th>Region 9:</th>
<th>Hinds Behavioral Health</th>
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<tr>
<td>Hinds</td>
<td>Margaret L. Harris, Director</td>
<td></td>
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<tr>
<td></td>
<td>P.O. Box 777, 3450 Highway 80 West</td>
<td></td>
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<tr>
<td></td>
<td>Jackson, MS 39284 (601) 321-2400</td>
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<tr>
<th>Region 10:</th>
<th>Weems Community Mental Health Center</th>
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<tbody>
<tr>
<td>Clarke, Jasper,</td>
<td>Maurice Kahlmu, Executive Director</td>
<td></td>
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<tr>
<td>Kemper, Lauderdale,</td>
<td>1415 College Road</td>
<td></td>
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<tr>
<td>Leake, Neshoba,</td>
<td>P. O. Box 4378</td>
<td></td>
</tr>
<tr>
<td>Newton, Scott,</td>
<td>Meridian, MS 39304 (601) 483-4821</td>
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<td>Smith</td>
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<tr>
<th>Region 11:</th>
<th>Southwest MS Mental Health Complex</th>
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<tr>
<td>Adams, Amite,</td>
<td>Steve Ellis, Ph.D., Director</td>
<td></td>
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<tr>
<td>Claiborne, Franklin,</td>
<td>1701 White Street</td>
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<tr>
<td>Jefferson, Lawrence,</td>
<td>P. O. Box 768</td>
<td></td>
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<tr>
<td>Lincoln, Pike,</td>
<td>McComb, MS 39649-0768</td>
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<tr>
<td>Walthall, Wilkinson</td>
<td>(601) 684-2173</td>
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<tr>
<th>Region 12:</th>
<th>Pine Belt Mental Healthcare Resources</th>
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<tbody>
<tr>
<td>Covington, Forrest,</td>
<td>Jerry Mayo, Executive Director</td>
<td></td>
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<tr>
<td>Greene, Jeff Davis,</td>
<td>103 South 19th Avenue</td>
<td></td>
</tr>
<tr>
<td>Lamar, Marion,</td>
<td>P. O. Box 1030</td>
<td></td>
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<tr>
<td>Perry, Wayne</td>
<td>Hattiesburg, MS 39403 (601) 544-4641</td>
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<tr>
<th>Region 13:</th>
<th>Gulf Coast Mental Health Center</th>
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<tr>
<td>Hancock, Harrison,</td>
<td>Jeffrey L. Bennett, Executive Director</td>
<td></td>
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<tr>
<td>Pearl River,</td>
<td>1600 Broad Avenue</td>
<td></td>
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<tr>
<td>Stone</td>
<td>Gulfport, MS 39501-3603 (228) 863-1132</td>
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<tr>
<th>Region 14:</th>
<th>Singing River Services</th>
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<tr>
<td>George, Jackson</td>
<td>Sherman Blackwell, II, Executive Director</td>
<td></td>
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<tr>
<td></td>
<td>3407 Shamrock Court</td>
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<td></td>
<td>Gautier, MS 39553 (228) 497-0690</td>
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<tr>
<th>Region 15:</th>
<th>Warren-Yazoo Mental Health Services</th>
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<tr>
<td>Warren, Yazoo</td>
<td>Steve Roark, Executive Director</td>
<td></td>
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<tr>
<td></td>
<td>3444 Wisconsin Avenue</td>
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<td></td>
<td>P. O. Box 820691</td>
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<tr>
<td></td>
<td>Vicksburg, MS 39182 (601) 638-0031</td>
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State-operated Facilities: DMH administers and operates six state psychiatric facilities, five regional centers for people with intellectual and developmental disabilities, and a juvenile rehabilitation facility. These facilities serve specified populations in designated counties/service areas of the State.

The psychiatric facilities provide inpatient services for adults with serious mental illness and children with serious emotional disturbances. These facilities include Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, Specialized Treatment Facility, and Central Mississippi Residential Center. Nursing facility services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital.

The Regional Centers provide on-campus, and community-based residential services for persons with intellectual and developmental disabilities. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

The Mississippi Adolescent Center (MAC) in Brookhaven is a residential facility dedicated to providing adolescents with intellectual and developmental disabilities an individualized array of rehabilitation service options. MAC serves youth who have a diagnosis of intellectual and developmental disabilities and whose behavior makes it necessary for them to reside in a structured therapeutic environment. The Specialized Treatment Facility in Gulfport is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment.

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

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

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

State Role in Funding Community-Based Services The authority for funding programs to provide services to persons in Mississippi with mental illness, mental retardation, and/or alcohol/drug abuse problems by the Department of Mental Health was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the MS Department of Mental Health is a general state tax fund agency. Section 41-4-7(1) of the MS Code states that the Department of Mental Health is:

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

The FY 2011 State Plan includes objectives related to state funds that were appropriated for specific purposes by the State Legislature in 2010-2011. Also included under Criterion 5 in the FY 2011 State Plan are objectives to request additional state funds for the 2012 fiscal year. Criterion 5 also reflects projected use of federal Community Mental Health Services (CMHS) Block Grant funds in FY 2011, including an increase in FY 2010 (current year) CMHS Block Grant funds. The DMH administers and grants to local providers funding from the federal CMHS block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as the PATH program). The DMH also applies to the MS Department of Human Services for a portion of Mississippi’s federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. Due to the budget reductions in FY 2010 and the potential for further budget cuts in FY 2011, modification to objectives may be required to this plan.

Agencies or organizations submit to the Department for review proposals to address needs in their local communities. The decision-making process for selection of proposals
Mississippi

to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health. Applications for funding are reviewed by staff in the DMH, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP, (2) the applicant's provision of services compatible with established priorities, and (3) availability of resources.

Organizational Structure and Development of the Comprehensive System of Care

Children’s System:
The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 15 regional mental health/mental retardation commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, family education and respite and prevention/early intervention services. Public inpatient services are provided directly by the MS Department of Mental Health (described further later under this criterion). The community mental health centers began providing outpatient services to children and adolescents with serious emotional disturbance as Medicaid reimbursable services in 1986 and served 29,269 children/youth with SED in FY 2008.

Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early Periodic Screening, Diagnosis and Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group and psychological and developmental evaluations. Psychological and developmental evaluations, services for children under age three (3) and services in excess of service standard must be prior authorized by the Division. The service standards are: Individual therapy, 36 visits per year, family therapy, 24 visits per year, and group therapy, 45 visits per year.

Mississippi’s System of Care for Children and Youth

Mississippi recognizes that a System of Care is a coordinated network of community-based services and supports based on the values of cultural/linguistic competency, family-driven and youth-guided care and community – based resources. A System of Care is not a program, but a philosophy of how care should be delivered. A System of Care considers all life domains rather than addressing just the mental health treatment needs in isolation. There are eight overlapping dimensions:
As one of the first states to create a foundation for systems of care, Mississippi continues the movement through legislation, initially passed in 1993. This first legislation, SB 2626, mandated pilot projects at the community level to study the effectiveness of local multidisciplinary assessment and planning teams for children and youth who needed multi-agency services. The Children’s Advisory Council was created with the goal to use pooled funding at the local and state level to better service those children and youth. This legislation was reauthorized in the 996, 1998, and 2001 Legislative Sessions. In 2001, HB 1275 and subsequently SB 2991 were enacted to establish a statewide system of care structure, with local Multidisciplinary Assessment and Planning (MAP) Teams around the state. This legislation created the Interagency Coordinating Council for Children and Youth (ICCCY) with membership represented by the Executive Directors of the following state child-serving agencies: MS Department of Education, MS Department of Mental Health, State Department of Health, Department of Human Services, Division of Medicaid (Office of the Governor), State Department of Rehabilitation Services and Mississippi Families As Allies for Children’s Mental Health, Inc. The ICCCY is charged with leading the development of the statewide system of care through the established Interagency System of Care Council (ISCC), consisting of a member of each state agency, a family member representing a family education and support organization, two special organization representatives, and a family member appointed by MSFAA. The ISCC services as the mid-level management teams with the responsibility of collecting and analyzing data and funding strategies, coordinating local MAP Teams, and applying for grants from public and private sources.

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

Adult System:

The majority of the public community mental health services for adults with serious mental illness in Mississippi is provided through 15 regional mental health/mental retardation commissions, which operate 15 regional community mental health centers serving all 82 counties of the state. As further discussed under Criterion #4 that follows, these centers operate regional or satellite offices/services in 81 of the 82 counties. The mental health centers are governed by regional commissions, with representative commissioners for each county in the region appointed by county Boards of Supervisors. As described in more detail in the Section I, the Mississippi Department of Mental Health sets and monitors implementation of minimum standards for community mental health programs certified through the authority of the DMH. Implementation of these standards, which establish minimum requirements for programs in organization, management and in specific services, is monitored through on-site visits of programs throughout the year by DMH staff. Some community services (such as case management, psychosocial rehabilitation, group homes and supervised apartments and specialized programs for homeless persons who are mentally ill) are also provided to some individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These services are primarily for individuals discharged from the hospital and are in the areas in close proximity to the hospitals (Jackson and Meridian). These programs are also monitored for implementation of minimum standards applicable to the community mental health programs they provide. Community mental health centers provide pre-evaluation screening for individuals referred for evaluation for commitment to the state inpatient facilities, which provide regionalized, inpatient services. The redesign of crisis stabilization unit services is described in the section that follows on Activities to Reduce Hospitalization.

In FY 2009, House Bill 897 called for the establishment of a Joint Legislative Study Committee and allowed for formation of an advisory council to the study committee, both of which were formed and began work last year. The committee was 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 2645, passed in the 2010 legislative session, extended the Legislative Mental Health Study Committee and added the disparity of services across community mental health regions, ongoing and long-term financing, and organizational structure of the community mental health system to topics the study committee will examine.
Ideal System Model

The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness was developed to reflect an ideal system that is responsive to the strengths and needs of all individuals with serious mental illness. At the center of the system is the person, each with his or her individual strengths and needs, which vary across time and circumstances. Revolving around the person and between the person and his or her family and components of the mental health and support system, is case management. Case management is the key to accessing and coordinating mental health and support services needed by the individual at any given time. In the ideal system, the case manager continually works with the individual to aid in identifying that person’s goals, helping them to recognize strengths and barriers, and in developing and implementing an action plan based on identified needs. The Ideal System Model for Adults emphasizes a psychosocial rehabilitation approach to making an array of appropriate mental health, social, vocational, educational, and other support options available, based on individuals' strengths, as well as their needs. Several types of service options and activities may be included in the service components of the Ideal System Model. A major change in the description of the characteristics of the system has been made to reflect a philosophy shift to one that is more person-directed and thus, individualized. Consistent with an initial 2006 Planning Council recommendation, strategies to evaluate and improve the effectiveness of local advisory councils, which include consumers and family members, have been included in system improvement efforts. The major service components of the Ideal System Model for Adults include: case management, outpatient services, crisis response services, alternative living arrangements (housing), identification and outreach, psychosocial rehabilitation services, family/consumer education and support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance abuse are also included in the system of community-based care.
IDEAL SYSTEM MODEL
Mississippi Comprehensive Community Mental Health System for Adults With Serious Mental Illness

CHARACTERISTICS OF THE SYSTEM
- Person - Directed
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- Emphasis on Recovery
Strengths and Needs of the Service System

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

- The Division of Children and Youth Services applied for and was granted funding for a third Mississippi Transitional Outreach Program (MTOP), a Children’s Mental Health Initiative targeting transitional-age youth, 16-21 years, The Mississippi Transitional Outreach Program (MTOP) will begin implementation October 1, 2010 in two Community Mental Health Center regions. On October 1, 2011 and 2012, two more regions will be added for a total of six four MTOPs by the end of the six year grant period, 2015.

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

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

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. Grant funding from the Department of Public Safety, Office of Justice Programs was received January 2010, to improve access to appropriate mental health services and supports from the local community mental health centers.

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

- The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges.

- The Fetal Alcohol Spectrum Disorder (FASD) Project has continued to focus on the screening and assessment of children, 0-7 years of age through the 15 Community Mental Health Centers. The Advisory Council of FASD is focusing on the treatment and services received by those children with a FASD to determine best practices for this target population.

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

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

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

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

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

- The need to increase respite services and family education/support services for those families and caregivers who undergo the constant strain of caring for youth with SED are needed to keep children/youth from being inappropriately placed in residential care.
Strengths: Services for Adults with serious mental illness (SMI)

- Implementation of the comprehensive service system for adults with serious mental illness reflects the DMH’s long-term commitment to providing services, as well as supports, that are accessible on a statewide basis. DMH has continued efforts to improve the clubhouse programs by providing technical assistance on the International Center for Clubhouse Development (ICCD) programs model; ICCD-certified programs have been developed that can serve as more cost-effective in-state training sites. The DMH Division of Community Services plans to expand the ICCD certified clubhouses to each region in the state.

- DMH has developed a range of community-based service options that can be accessed to address the individualized and changing needs of individuals with serious mental illness, such as elderly senior psychosocial rehabilitation services and day support. DMH continues to offer three training sites in Regions 6, 12, and 15.

- DMH has maintained a long-term commitment to improve its system of crisis response and continuity of care for individuals who have been or who are at risk for hospitalization. Addressing this issue requires multiple strategies, given interaction with local courts around civil commitment, the fact that individuals and families in crisis frequently lack financial resources, as well as the limited resources of many local communities to address emergency care needs. The Department of Mental Health has developed two transitional group homes in the Region 3 CMHC service area for individuals with mental illness and intellectual disabilities who have been frequent users of the justice system and the state psychiatric hospital system.

- Regionalization of acute care/crisis services has been advanced through the opening of two, 50-bed acute psychiatric hospitals for adults to serve the northern and southern areas of the state. DMH is in the process of transitioning the operation of six of the seven crisis centers to the local community mental health centers to allow for more seamless admission and transition of individuals back to the local community. DMH also plans to continue funding two other intensive residential treatment programs operated in previous years by community mental health centers. Total capacity of all the centers will more adequately address a major unmet need for access to crisis intervention and stabilization services on a statewide basis. Regionalization of acute care/crisis services has been advanced through the opening of two, 50-bed acute psychiatric hospitals for adults to serve the northern and southern areas of the state. DMH funds seven (7) sixteen (16) bed Crisis Stabilization Units and partially funds one (1) twenty-four (24) bed Crisis Stabilization Units throughout the state. All but one (1) are operated by the Community Mental Health Center Regions. All Crisis Stabilization Units take voluntary as well as involuntary admissions.
The DMH Division of Community Services and the DMH Bureau of Alcohol and Drug Abuse Services have a history of consensus and collaboration in continuing efforts to better address the needs of individuals with co-occurring mental illness and substance abuse disorders. DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. In 2010, DMH received federal Transformation Transfer Initiative (TTI) funding that will facilitate training on effective conducting assessments, developing treatment plans, and providing integrated services and treatment for co-occurring disorders in community mental health regions and state hospitals that have not received the training in the previous year.

The perspectives of individuals receiving services and families have long been important in planning, implementing and evaluating the adult service system, contributed through their involvement in numerous task forces, the peer review process and more recently, through provider education and the person-directed planning process. The Division of Consumer and Family Affairs has implemented initiatives to provide more specific guidance regarding the purpose and structure of local advisory councils, has developed a draft of a manual to provide technical assistance to the local advisory councils and plans to develop a strategy for dissemination of educational information to the local councils.

The DMH maintains an accessible, structured system for reporting and resolving of grievances and problems in programs certified by the agency (both formally and informally), as well as for providing information on statewide service availability, through its Office of Constituency Services (OCS). OCS maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. The OCS has also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran. The OCS maintains a 24-hour, toll-free assistance line, as described in more detail in Section III. in both the Children’s Services and Adult Services Plans.

The DMH Division of Community Services has continued to work closely with other agencies, such as the Division of Medicaid, to plan and implement system changes. DMH continues to work with the Division of Medicaid to explore the possibility of a proposed State Plan Amendment and/or a waiver for submission to the Center for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community based services to further support resilience/recovery.
Efforts to address outreach and specialized approaches that are more responsive to the needs of individuals with serious mental illness who are homeless have involved ongoing collaboration and creativity among the DMH and other agencies and organizations that serve homeless persons. DMH was recently approved to receive the SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance to provide specific training to PATH and housing providers and other stakeholders. The DMH has collaborated with The Social Security Administration, Disability Determination Services, Veterans Affairs and other organizations to plan SOAR Training for various regions across the state. In March 2011, DMH conducted its first SOAR Training for providers.

DMH has continued to emphasize the importance of the role of case management in the adult service system and provides case management orientation for local service providers on an ongoing basis throughout the year. A Case Management Task Force has maintained its focus on improving case management services, including linkage with other types of support services. Also as mentioned, the DMH has completed work on development of a Case Management Certification Program for individuals working in the public mental health system. The process to become a Credentialed Certified Case Management Professional has been revised to adjust to the accessibility and innovation of distant learning technology. The requirement for initial orientation to service delivery can now be completed online.

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. The Bureau of Community Services will also continue efforts to obtain funding support to provide peer specialist services, including submission of an application for a SAMHSA Mental Health Transformation grant.

As noted under the strengths for children’s services, continuity of administration and experience at both the state and local levels among service providers and
Mississippi advocates have facilitated adherence to ideal system model principles and progress in addressing gaps in the system.

- Additionally, as in the implementation of the children’s services systems, recognition of and commitment of resources to providing training, including technical assistance and credentialing programs, characterize strategies for quality improvement for all adult services.

- To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year statewide Anti-Stigma Campaign. The first year of the statewide campaign was launched on May 2, 2007, with a press conference in Jackson, MS. The campaign, which is entitled “What a Difference a Friend Makes,” was designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems. Because the campaign targets the transitional age range, this transformation objective was included in FY 2008 through FY 2010 in both the Children’s Services and Adult Services State Plans. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign, which reached an estimated 1 million individuals in FY 2008. In October 2009, DMH and the statewide Anti-Stigma Committee will launch a campaign specific to Mississippi entitled, “Think Again.” The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. It will continue to show young adults how to support their friends who are living with mental health problems.

- To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) and the Think Again Network launched a mental health awareness campaign entitled, Think Again. The campaign, which was launched in 2009, was designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems. DMH established an Anti-Stigma Committee with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign, which reached an estimated 1 million individuals in FY 2010. In DMH and the Think Again Network will continue to show young adults how to support their friends who
are living with mental health problems. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. Combined, these campaigns teach young adults about mental health and suicide prevention. Materials and presentations for both campaigns were combined in order to present a more concise and consistent message.

- In 2009, the DMH Division of Community Services continues worked to develop and pilot three AMAP (Adult Make A Plan) Teams. Division of Community Services staff will collaborates with Division of Children and Youth Services staff to receive training on wrap-around services; the Division will also work is working with the person-directed planning training sites in Regions 12 and 15 to include this approach in AMAP training. In 2011, the Division of Community Services added an additional AMAP Team in Region 4. DMH will continue to support and expand AMAP efforts across the state. DMH anticipate funding cuts in both of these areas. DMH however continues to explore other funding avenues to maintain and expand these services. In 2012, it is anticipated that the Division of Community Services will add 5 additional AMAP teams across the state.

Needs: Services for Adults with serious mental illness (SMI)

- The need for additional transportation options, with more flexible scheduling, continues to be a need across the state for individuals with disabilities, including individuals with serious mental illness. Maximizing transportation resources available across agencies is key to providing individuals with services and supports that enable them to be independent, such as employment and housing. Additional resources are needed to begin implementation of the plan for transportation that is being developed by the Mississippi Coordinated Transportation Coalition. The DMH continues with the Coalition to explore funding opportunities to consistently coordinate transportation planning in the state. DMH will utilize small funding streams to assist in piloting the provision of transportation to individuals with disabilities.

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

- Development of a comprehensive strategic plan to expand housing options statewide for persons with serious mental illness is needed to support recovery.

- Continuation of law enforcement training to reach additional experienced officers in communities, as well as strategies to address needs of other emergency services personnel is needed. Additional efforts are being made to address this issue through increased education and networking with law enforcement associations. DMH will utilize small funding streams to assist in the cost of these rides to individuals with disabilities.
The Division of Community Services is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. DMH makes grants available to CMHC regions to provide training to law enforcement and has also explored several funding opportunities to facilitate the establishment of Crisis Intervention Team (CIT) training of officers in the state.

Continued focus on improving transition of individuals from state hospitals, back to their home communities is needed, in particular, development of strategies to better target and expand intensive supports, preferably through a team approach. Currently plans are to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.

As in the children’s services systems, increasing the skill-level of community mental health service providers to affect system changes reflected throughout the plan remains a need.

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

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

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

DMH administrative staff also evaluate the status of the system against national trends and reports, such as the Report of the President’s New Freedom Commission on Mental Health (July 2003), SAMHSA’s Strategic Initiatives and feedback from State Plan review meetings and on-site monitoring visits. Similarly, staff review and consider feedback received through annual external review of the State Plan; a copy of the review report is also provided to the Planning and Advisory Council and the State Board of Mental Health.
As reflected in the State Plan, the DMH tracks progress on specific, annual objectives that are steps toward broader system goals to increase services or enhance existing services within service systems. Progress on these objectives is tracked by analyzing aggregate reports of administrative data received from local community service providers and data maintained by Central Office staff within an internal report system (reports of on-site visits to service providers, Central office staff activity logs/reports, task force minutes and reports, etc.). Results of these on-site visits, as well as of peer review visits, are documented through a structured reporting and feedback system that includes required plans of correction that address deficiencies in meeting minimum operational standards set by DMH. DMH staff make follow-up visits to monitor implementation of approved plans of correction. Such ongoing, regular visits to local programs are key to identifying unmet needs. Administrative data from the state psychiatric hospitals are also routinely submitted/ reviewed by DMH management staff. Efforts to transition to a central data repository system, as well as to integrate consumer and family satisfaction and additional data focusing on system-level and consumer and family-centered outcomes to better evaluate progress on objectives continue. DMH’s federal data infrastructure grant is being used to support much of this work.

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

The DMH also continues to gain direct feedback on unmet needs from family members, consumers, local service providers, and representatives from other agencies through numerous task forces that focus on critical issues (such as co-occurring disorders, homelessness, children’s services and case management). The DMH has also benefited greatly from the continuity of its relationship with the MS State Mental Health Planning and Advisory Council, which reviews the DMH’s progress on implementation of state plan objectives, both during and at the end of every year. The Council also established a Long-Range Planning Committee, in June 2005 and made it a Standing Committee, in August 2009; the committee is charged with making recommendations for further advancing and sustaining community-based services and supports. Beginning in FY 2007, the Consumer Rights Committee of the Council surveyed stakeholders, including participants at the Consumer Conferences, for additional input on issues to focus their work and subsequently made recommendations to the full Council. The DMH is implementing statewide consumer and family (for children) satisfaction surveys as another means of collecting feedback from individuals served by the system.
In addition to considering estimates of prevalence for the targeted groups, results of a statewide consumer survey, public forums and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness; for example, major needs for housing and transportation were identified.

The DMH Division of Children and Youth Services gains additional information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) teams, and through the work of the State-level Interagency Case Review Team, the Interagency Coordinating Council for Children and Youth (ICCCY), the 2nd and two Comprehensive System of Care Projects, commUNITY cares and the Mississippi Transitional Outreach Program (commUNITY cares) in three counties of the state, and the 3rd Comprehensive System of Care Project (Mississippi Transitional Outreach Program), all of which are described in more detail in the State Plan.

As described in the State Plans for children and adults, The DMH management staff also receive regular reports from the Office of Constituency Services (OCS), which as mentioned, tracks requests for services by major category, as well as receives and attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system.

Federal and State Resources

(To be updated)
The FY 2011-2012-2013 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2010-2011 Session. Also included under Criterion #5 in the Children’s Plan and in the Adult Plan are objectives to request additional state funds for the 2012 fiscal year. The Department of Mental Health (DMH) administers and grants to local providers funding from the federal Community Mental Health Services (CMHS) block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants. The DMH also applies to the MS Department of Human Services for a portion of Mississippi’s federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) If SSBG funding, which totals $1.2 million for mental health services for adults and children, is no longer available in FY 2011, modifications to the plan may be required. The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. For the past nine years of budget restrictions, the community mental health centers have also made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers. In FY 2011, projections are that between $24 and $32 million will be needed for match on CMHC Medicaid payments; the higher
amount will be needed if the enhanced federal share of Medicaid under ARRA is not extended until June 30, 2011.

The legislation that provides for the establishment, structure and operation of the regional commissions for mental health/mental retardation also authorizes participating counties to levy up to two mills tax for programs designed by the regional commission. The DMH also performs fiscal audits of programs receiving funding through its Bureau of Administration.

Sources listed under the heading of “Funding” within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under “Funding” does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited.
III. State Priorities in FY 2012-FY 2013

Table 2  Plan Year FY 2012-2013

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Priorities and Plans to Address Unmet Needs in FY 2011

a) Children’s Mental Health System

Priority: Fetal Alcohol Spectrum Disorder

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

Priority: Staff Training
Plans: As described throughout the State Plan for Children’s Services, particularly under Criteria 3 and 5, the DMH Division of Children and Youth Services plans to continue its emphasis on training to increase the skills of community services providers and to facilitate retention of staff, and therefore, continuity of care. The Division of Children and Youth Services also plans to continue its support and participation in statewide conferences that involve staff from other child and family service agencies, such as the Annual Lookin’ to the Future Conference, the Juvenile Justice Conference, the conference of the MS Alliance of School Health (MASH), and other workshops to include youth suicide prevention, wraparound, system of care, evidenced-based practices, and interagency collaboration.

Priority: Working with Schools

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

Priority: Expanding Evidenced-based Practices

Plans: The DMH plans to continue to track progress and products initiated through the Mississippi Trauma Recovery for Youth (TRY) project, implemented by Catholic Charities, Inc., which continues to be a member of the National Child Traumatic Stress Network (NCTSN). The goal is to improve the quality, effectiveness and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward that goal, learning collaboratives focused on adoption and implementation of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) will continue to be developed as funds are available; 11 sites in Mississippi, including the Gulf Coast Mental Health Center, were involved in the initial learning collaborative. Currently, TRY is undergoing the first learning collaborative for Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPRARCS), which is a group intervention that was specifically designed to address the needs of chronically-traumatized adolescents who may continue to be living with ongoing stress and are experiencing problems in several areas of functioning.

DMH Division of Children & Youth in collaboration with the Division of Medicaid has provided Wraparound and System of Care training through the Innovations Institute at the University of Maryland for providers of the SED Waiver Demonstration Grant and the MAP Team.
Coordinators. Plans are to implement this Wraparound model across the state as further training, technical assistance, and coaching is provided by staff from Innovations Institute.

Priority: Housing Supports for Families

Plans: In FY 2010, the DMH continued to work with the MAP teams to focus planning on increasing housing supports for youth with serious emotional disturbances, who may be living at home, but who are nonetheless, at risk for homelessness. Typically, these children have single mothers living at or below the poverty level. The team will continue to focus on transition planning at the inpatient/residential site for institutionalized children to facilitate more stable housing, potentially through other supports, such as education on financial management or adequate supervision of children at home that allows the mother to maintain employment. Additionally, efforts continue to focus on mothers and their children living in a domestic violence program/center and their transitioning back to the community with appropriate housing supports. The Director of the Mississippi Transitional Outreach Program (MTOP) also serves on the Housing Task Force established by DMH in FY 2010.

Priority: Continued Interagency Collaboration Activities/System of Care

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

Priority: Interagency Efforts with Juvenile Justice

Plans: A DMH Division of Children and Youth staff member has been assigned as the Juvenile Mental Health Coordinator for the Juvenile Assistance Grant received by the Department of Public Safety. The Coordinator is identifying the current needs of the 17 local detention centers across the state and the community mental health centers regarding access to mental health services for those youth admitted in the detention centers.

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

Priority: Strategies to Meet the Needs of Youth in Transition
Mississippi

**Plans:** A Transition Age Task Force, which is chaired by the staff person who is also coordinating the division’s work with youth in transitional ages in community-based services will continue to operate. The DMH also plans to continue funding that was redirected to support transitional living programs operated by the CMHC in Region 12 and by another nonprofit service provider, specifically targeting the needs of youth in transition and facilitating access to a variety of living situations/housing and supports, depending on the needs of the individual youth. There service providers have shared specific strategies with other service providers on the Transition Age Task Force.

DMH Division of Children & Youth received a 3rd Comprehensive System of Care Initiative in October 2009 that will target transition-aged youth, 16-21 years. The Mississippi Transitional Outreach Program (MTOP) begins the first implementation year, October
Section III: Performance Goals and Action Plans to Improve the Service System

(a) FY 2011 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

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

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness

- Describes available services and resources in a comprehensive system of care. This consists of services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities,

- including services for individuals diagnosed with both mental illness and substance abuse.

Ideal System Model

The development of children’s mental health services in Mississippi was established as a priority of the Department of Mental Health in 1980, through the State Board of Mental Health’s creation of a Division of Children and Youth Services within the Bureau of Mental Health. The Department and the MS State Mental Health Planning and Advisory Council developed an Ideal System Model for the Mississippi Comprehensive Community Mental Health System for Children with Serious Emotional Disturbance (see Figure that follows), upon which long-term goals were based. Realistic annual objectives have been formulated to address gaps in the system, given available human and fiscal resources, while efforts to sustain and increase resources have been ongoing. All goals and objectives continue to represent ongoing efforts to develop a comprehensive system of care for children represented by the Ideal System Model for community-based services. The time line for all objectives in the FY 2011 plan for children is October 1, 2010, through September 20, 2011.

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

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

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

System-wide support services now include an array of substance abuse services administered by the Department of Mental Health. The inclusion of substance abuse services as a system-wide support emphasizes the Division of Children and Youth Services’ intent to expand and strengthen linkages that make substance abuse services more accessible and responsive to the needs of youth who also have a serious emotional disturbance.

The mental health and support system components of the system are more likely to change as the needs and strengths of children and families change. Inherent in the Ideal System Model are the characteristics of consistency, based on service philosophy and values, and flexibility, to allow for responsiveness to changing needs and service environments.

The major service components of the Ideal System Model For Children include: prevention, early intervention, diagnosis and evaluation, case management (school-based case management, individual therapeutic support, and mental illness management services), crisis intervention, outpatient services, day treatment, respite services, community-based residential services, protection and advocacy, family education and support, inpatient services, other support services, and system-wide support services.

Efforts to enhance interagency collaboration, including operation of a State Level Interagency Case Review/MAP team, local interagency MAP (Making a Plan) teams, and in more recent years, the Interagency Coordinating Council for Children and Youth (ICCCY) reflect the establishment of structures that build on families’ strengths while addressing the special needs and circumstances of children. The Plan also describes continued efforts to increase the availability, accessibility and quality of children’s services across the 15 community mental health regions.

**b) Adult Mental Health System**

**Priority: Consumer-directed Activities**

**Plans:** The Division of Consumer and Family Affairs has identified dissemination of a philosophy of more individualized, person-directed assessment and treatment through training and followup with professionals and stakeholders involved in the process as key to realization of a recovery-oriented system. The objectives of the Division are as follows: (1) To ensure that consumers of mental health services and families of consumers of mental health services are the driving force for improvements in the publicly funded mental health system; (2) To help individuals and their families participate in the decision making at all levels of our public mental health system; and (3) promote the empowerment of individuals and families with mental health
needs through education, support, and access to mental health services. The Division of Consumer and Family Affairs plans to continue its focus on improving the peer review process to better assess if programs are recovery-oriented. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person-driven, evidence-based, recovery-oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011. The division also plans to continue supporting consumer education and support programs provided through NAMI-MS (such as Peer to Peer) and the Mississippi Leadership Academy. The Mississippi Leadership Academy was implemented in 2006, with over 100 participants thus far. Persons who have participated in Peer-to-Peer training, or other state supported educational trainings or who are interested in increasing their leadership skills will be provided an opportunity to participate in the Academy, as resources are available. In FY 2011, the Division of Consumer and Family Affairs will continue to work with other divisions in DMH to make available education and informational materials about recovery and empowerment. The division will also continue its work to develop the peer specialist program, including providing education to the mental health provider system about meaningful roles for peer specialists, as well as to explore the feasibility of training family peer specialists. Currently, Certified Peer Specialists are working to establish bylaws, goals and a mission statement for Recovery Now, a newly formed consumer coalition. In FY 2010, two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. In FY 2011, the Bureau of Community Services will continue to explore areas to employ Peer Specialists and educate community mental health systems on the role of Peer Specialists in the recovery process. In 2010, DMH applied for Mental Health Transformation grant through SAMHSA, which if funded, will include development of Peer Specialist employment and education opportunities for an increased number of consumers. Additionally, in FY 2011, the Division of Consumer and Family Affairs will continue activities to facilitate the establishment of an independent consumer coalition. In FY 2010, the Division of Family and Consumer Affairs collaborated with other groups to identify consumers interested in assuming leadership roles in developing a statewide consumer coalition and by seeking guidance on steps to move forward in forming and supporting the coalition, possibly through holding a retreat of identified consumer leaders to discuss forming and supporting a coalition. The Division of Consumer and Family Affairs will continue to work with the newly formed consumer coalition group, Recovery Now, by providing requested support and technical assistance.

**Priority: Crisis Services**

**Plans:** 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; one center had been transitioned as a pilot program in Grenada in FY 2009. This transition will be complete by June 30, 2010, and community mental health centers will begin operating five of the remaining six units. The DMH will continue collaboration and support of all seven crisis stabilization units, based on the redesign piloted in Grenada, which includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services. The DMH Division of Community Services plans to continue efforts on developing a structure that more effectively targets intensive supports to individuals being discharged from crisis intervention programs or inpatient psychiatric facilities, such as through development of transition planning teams at the hospitals that work closely with community mental health centers and individuals receiving services and if
appropria, with their families. DMH plans to continue support of transitional group homes and supervised living options in the north and central part of Mississippi.

Priority: Transportation

Plans: As described under the Significant Achievements in FY 2009 for Adults in Section I, the DMH Division of Community Services continued an initiative begun with the Division of Medicaid through a transportation committee that is seeking to maximize funding for and the use of transportation for individuals with disabilities. In general, as conceptualized in preliminary discussions, a coordinated system of transportation that involves more efficient and effective scheduling and dispatching of transportation resources to prevent duplication is envisioned. Such a system would ultimately provide individuals with more flexible options that are necessary for them to pursue goals of employment and more independent living arrangements in the community. The DMH Division of Community Services implemented a Rebalancing Initiative grant awarded by the federal Center for Medicare and Medicaid Services (CMS) to develop a coordinated system of transportation in two mental health regions of the state—Region 4, located in the northeastern part of the state, and Region 15, located in the west central part of the state. Planning meetings have continued, and the Mississippi Transportation Coalition was established that includes key stakeholders, including major state agencies that provide and/or support transportation, advocacy groups and individuals receiving services. Following Hurricane Katrina, DMH was awarded a supplemental grant to coordinate transportation in Hancock County (Region 13) on the coast, which was severely impacted by the storm. Since that time, a coalition has been formed in Hancock County, made up of transportation providers and consumers from the Gulf Coast. The goal was to replicate the statewide transportation plan in Hancock County, where services were devastated by Hurricane Katrina. As part of the Coalition’s planning work, two grants were funded for two years by the Mississippi Council on Developmental Disabilities to implement some of the recommendations of the Coalition for the statewide transportation system on a test basis. Also, as part of the Coalition’s work on the coast, transportation services were set up in Hancock County. CMS funding of the Rebalancing Initiative for coordinated transportation planning ended in September 2008. The Mississippi Transportation Coalition, which includes DMH representatives, continues to meet and seek additional funding avenues to pilot strategies developed by the Coalition to address unmet transportation needs. Supported through funding from the TTI and the FY 2010 CMHS Block Grant increase, DMH will continue implementation of a project piloting a coordinated transportation effort in the state. DMH will purchase transportation services for individuals with mental illness to maximize employment, housing and other community inclusion activities.

Priority: Specialized Services and Supports for Elderly Persons

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

Priority: Additional Housing Options

Plans: The DMH plans to continue to help support and monitor the provision of a range of community living options for individuals with serious mental illness, including transitional residential programs, group homes and supervised housing, including recently certified transitional group homes in Region 3 for individuals with mental illness and mental retardation who have been frequent users of the justice system and the state psychiatric hospital system. Efforts to develop more housing options for individuals with serious mental illness will continue. The possibility of dedicating a staff position to address this significant need is under consideration. The Division of Planning in the Bureau of Community Services will continue to participate in the NASMHPD Housing Task Force and coordinate the Housing Task Force established by DMH in 2010. The DMH will also continue 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.

Priority: Services for Individuals with Co-occurring Disorders

Plans: As described in the State Plan under Criterion 1, the DMH Division of Community Services plans to continue to provide financial support and technical assistance to community mental health centers to implement guidelines for specialized services for individuals with co-occurring disorders. The focus of activities will be on continued training and monitoring to facilitate implementation of a truly integrated system of care for persons with co-occurring disorders of mental illness and substance abuse. Also, as mentioned previously, the DMH plans to continue its state office activities to further develop and implement action steps that were included in a more specific, statewide strategic plan developed by state and local representatives with technical assistance from the national Co-occurring Disorders Center for Excellence (funded by SAMHSA). In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to ensure that uniform services are being provided to individuals with co-occurring disorders of mental illness and substance abuse. In FY 2009, statewide training on the evidence-based practice of integrated treatment was initiated to facilitate the provision of uniform, evidence-based services to individuals with co-occurring disorders of mental illness and substance abuse. The use of the GAIN Short Screener as a standard screening instrument will continue to be required, and the federal Transformation Transfer Initiative to facilitate training on effective assessment and treatment of co-occurring disorders in community mental health regions and state hospitals that have not received the training in the previous year will continue.

Priority: Psychosocial Rehabilitation Programs

Plans: The DMH plans to expand ICCD-certified clubhouse programs to a minimum of one per region and to explore incentives to programs to achieve that ICCD status.

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

**Plans:** As described in more detail under Criterion 5 in both the Adults’ and Children’s Services Plans, the DMH plans to maintain the availability of training for law enforcement personnel and monitor the provision of other training provided at the local level to address the needs of other emergency services personnel. An additional initiative related specifically to better assessing and treating trauma among children/youth is also described in the Children’s Services Plan. Because of budget restrictions, DMH will not continue funding provided in FY 2010 for law enforcement training provided by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers and explore other avenues for funding and 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. DMH will also collaborate with local law enforcement and community mental health centers in the development of Crisis Intervention Teams (CIT).

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

**Priority: Data Infrastructure Improvements**

**Plans:** As described under Criterion 5 in both the Children’s and Adults’ Services Plans, the DMH is continuing its efforts to conduct a planning and data mapping process necessary to construct and implement a central data repository for public mental health information management at the DMH Central Office. It is anticipated that this process, which will enable the state to report federal Uniform Reporting System (URS) information, will be continued in FY 2011. The DMH will also continue to implement statewide assessment of satisfaction of adult consumers and families of children with the services they receive through the public community mental health system. Funds from a federal Data Infrastructure Grant (DIG) Quality Improvement project provided by CMHS will continue to be used to support this process, which will ultimately facilitate better availability, quality and integration of process and outcome data needed to support ongoing work of the Planning Council and other quality improvement efforts. If its application for another three years of funding for the data infrastructure project is funded, DMH will pursue project plans to refine and implement a strategic plan for reporting client-level data for the National Outcome Measures targeted by CMHS, for refining infrastructure and processes for data collection and reporting, as well as for improving data integrity.

**Priority: Continued Involvement of Individuals Receiving Services and Families**

**Plans:** As noted throughout the State Plan, the DMH plans to continue involvement of consumers and family members through numerous task forces, the peer review process, and the MS State Mental Health Planning and Advisory Council. Structured orientation of new Planning Council members will be continued, as well as administrative support of the Council and its committees. As mentioned, the MS State Mental Health Planning and Advisory Council established an ad-hoc Long-Range Planning Committee in FY 2005, which includes individuals receiving services and family members, to explore in more depth needs, issues and recommendations for continued development of community-based services and supports. With Council approval, the committee was extended into FY 2010, and a recommendation for extension and expansion of the committee’s work to include continuity of care issues will be
presented to the full Council. The Consumer Rights Committee and the Children’s Services Task Force, both of which include consumers and family members, will also continue their work in FY 2011.

**Priority: Cultural Competence**

**Plans:** As described in both the Children’s Services and Adults’ Services Plans, the DMH plans to continue its commitment to both require and provide training in cultural diversity. The DMH plans to continue operation of the Multicultural Task Force, with continued focus on assisting local providers in assessing the cultural competence of their organizations and to plan to address the results of those assessments. The task force has also developed a draft model statewide cultural competence plan for the service delivery and organizational levels.

**Priority: Training**

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

**Priority: Wrap-Around Services**

**Plans:** In 2010 the DMH Division of Community Services will continue work to pilot three AMAP (Adult Make A Plan) Teams in community mental health regions 6, 7, and 8. The programs are in initial stages, developing community partnerships with interested agencies/organizations. The Division will continue funding this effort and will begin exploring funding avenues to expand AMAP services into other CMHC regions. The Division of Community Services for adults will continue to collaborate with the Division of Children and Youth Services, which has implemented Making A Plan (MAP) teams for youth in all 15 regions, to receive training on wrap-around services. The Division of Community Services will work with person-centered planning training sites in Regions 12 (Pine Belt Mental Healthcare Resources) and 15 (Warren-Yazoo Mental Health Services), to address a person-directed philosophy as part of this training for AMAP team development. The Division of Children and Youth Services has partnered with the Division of Medicaid to provide Wraparound training to MAP Team Coordinators and other providers utilizing the model of the Innovations Institute at the University of Maryland. DCS hopes to maintain funding to Regions 6, 7, and 8, for AMAP teams, which are modeled on the MAP teams for children, but are designed to meet the needs of adults.

**Priority: Monitoring of Use of Financial Resources**

**Plans:** The DMH plans to maintain its system of internal fiscal and property auditing within programs it directly operates. The DMH Division of Audit in the Bureau of Administration plans to continue their activities to monitor use of resources by all local providers certified and
Mississippi

funded by DMH to assure that the DMH-funded activities of the sub-recipients are in compliance with applicable laws, regulations, policies, and procedures.
IDEAL SYSTEM MODEL
Mississippi Comprehensive Community Mental Health System
for
Children With Serious Emotional Disturbance

CHARACTERISTICS OF THE SYSTEM
- Child and Family-Centered
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- System is Community-Based
- Emphasizes Both Service Availability and Advocacy and Support Networks
Organizational Structure and Development of the Comprehensive System of Care

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 15 regional mental health/mental retardation commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families—primarily community-based residential services, specialized crisis management services, family education and respite and prevention/early-intervention services. Public inpatient services are provided directly by the MS Department of Mental Health (described further later under this criterion). The community mental health centers began providing outpatient services to children and adolescents with serious emotional disturbance as Medicaid reimbursable services in 1986 and served 29,269 children/youth with SED in FY 2008.

Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early Periodic Screening, Diagnosis and Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family, and group and psychological and developmental evaluations. Psychological and developmental evaluations, services for children under age three (3) and services in excess of service standard must be prior authorized by the Division. The service standards are: Individual therapy, 36 visits per year, family therapy, 24 visits per year, and group therapy, 45 visits per year.

The Children’s Health Insurance Program (CHIP) also includes inpatient and some outpatient mental health services, as well as substance abuse services from approved providers, within specified limits. Mental health services include outpatient care. Precertification/prior authorization for inpatient care and partial hospitalization by network provider is required.

The Children’s Health Insurance Program (CHIP) also includes inpatient and some outpatient mental health services, as well as substance abuse services from approved providers, within specified limits. Mental health services include outpatient care. Precertification/prior authorization for inpatient care and partial hospitalization by network provider is required.

Sources listed under the heading of “Funding” within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under “Funding” does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited.

System of Care Development

Since system development historically has emphasized interagency collaboration, most objectives pertaining to system of care development are included under Criterion 3. As is evident throughout this plan, the process of development of the system of care in Mississippi has involved many concurrent and overlapping initiatives, during the past decade. Since 1980, the development of the system of care has involved cooperative administrative and policy changes at the state and local levels, which in some areas were facilitated by legislation. The Ideal System Model is based on a philosophy of services reinforced in the state through the implementation of statewide and local Child and Adolescent Service System Projects (CASSP) in the mid-1980’s and the 1990’s. DMH and the MS State Mental Health Planning and Advisory Council, including the Children’s Services Task Force of the Planning Council, have worked to develop program
Mental Health Transformation Activities: Improving Coordination of Care Among Multiple Systems

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

Wrap-Around Approach and Local MAP Team Development: The concept of using first the State-level Interagency Case Review Teams to address the needs of youth with a history of or at high risk for hospitalization or institutionalization has continued to be a major strategy in development of the system of care. Initial efforts to pilot this system-based wraparound approach in the state at the local level were through the Mississippi Connections project utilizing a designated amount of state resources from major child/family service agencies (representing mental health, human services (child welfare), education, health and Medicaid).

Mississippi Families As Allies for Children’s Mental Health, Inc. (MS FAA) and Pinebelt Mental Healthcare Resources (Region 12 CMHC) are partners with the DMH Division of Children and Youth Services in leadership, staffing, and support of the five-year project, which has been named commUNITYcares (uniting neighborhoods—integrating through youth). This project is in its third year of implementation, during which services are being provided through the wraparound process for children affected by severe emotional disturbance (SED) and or co-occurring SED and substance misuse in a region of the state (Forrest, Lamar and Marion counties) that has high need for, but low availability of services that could have also served as a model for other rural areas. DMH, Division of Children and Youth Services was also awarded a six-year System of Care grant October 1, 2009, that will focus on the development of services and programs for transition age youth (16-21 years) in six community mental health center regions across the state.

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

In Mississippi, as the concept of wraparound is implemented further, it is expected that individualized service plans be designed through a family- and child-driven, strengths-based needs assessment process. A team, including representatives of the family and various child and family service providers, develops the initial service plan for a child. The wraparound process, as demonstrated by the COMPASS project and commUNITYcares, takes advantage of an interagency, interdisciplinary approach through which some providers have access to flexible, non-categorical funding. Additionally, local interagency and family Making a Plan (MAP) teams will continue to be supported in implementation of a strengths-based assessment approach that leads to use of the child’s and family’s strengths in defining and providing an appropriate, coordinated array of services and supports. Presently, community mental health children’s service providers in 15 CMHC regions of the state are using this approach through MAP teams. Currently, there are 37 MAP Teams with plans for expansion in FY 2011.

MAP Team Coordinators meet bimonthly to obtain further training and technical assistance from DMH Division of Children & Youth Staff or representatives from other child serving agencies, and Mississippi Families As Allies for Children’s Mental Health, Inc. In FY 2010, MAP Team
Coordinators and their local members, family/parent groups, as well as members of the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC) participated in the development of the Mississippi System of Care Assessment and Study. This study, coordinated by the Center of Mississippi Health Policy, gathered stakeholder and family input for the revision of the MS System of Care legislation, HB 1529 which passed during the 2010 Regular Session.

Quality Improvement System Development

Some of the specific parameters of the Mental Health Reform Act (Senate Bill 2100) passed during the 1997 Session of the Mississippi Legislature that continue to impact development of the system of care for children/youth with SED are those provisions that address uniformity of services, establishing interagency agreements, timeliness of services, crisis services, and overall accessibility of services. The Department of Mental Health continues to implement various provisions of SB 2100, which is expected to increase the availability and uniformity of community-based services statewide. Consistent with the call for increased access, quality and accountability of services in the Mental Health Reform Act, the Mississippi Department of Mental Health continues work to improve its system of program evaluation and planning, a key focus of which is further development of its data infrastructure and information management systems. These efforts also address improving performance and outcome measurement and reporting at the local and state levels, including increasing capacity to report on National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Goal: To continue development of the program evaluation system, including implementation of the requirements of the Mental Health Reform Act of 1997 (SB 2100), to promote accountability and to improve quality of care in community mental health services.

Peer Review

In addition to monitoring community mental health service providers’ compliance with minimum standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in children/youth mental health services from among staff at community programs certified by the DMH. In FY 2008, the Division of Consumer and Family Affairs was created and took on the responsibility of coordinating the peer review process for adult services and children’s services. Based on feedback from satisfaction surveys in FY 2008, revisions were made to improve the peer review process for FY 2009. Peer review visits in FY 2009 involved a smaller, more focused team of one consumer representative, one family member and one stakeholder. During the review, a sample of each type of program is visited. The Division developed a manual/guide for Peer Reviewers that describes available services by region, and core services; thumbnail images of service locations were placed next to addresses. A pre-conference visit is also held with service providers, in addition to the exit conference at the close of the visit. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person driven, evidence-based, recovery oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011.
Combined Objectives, Strategies and Performance Indicators for the SMHA (State Mental Health Authority) and the SSA (State Substance Abuse Authority)

State Priority #1: Integration of Behavioral Health and Primary Care Services

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

The FY 2012 State Plans for Community Mental Health and Alcohol and Drug Abuse reflect the elements in the Department of Mental Health’s Ten-Year Strategic Plan which encompasses Integration of Behavioral Health and Primary Care Services, Recovery Supports and Provision of Services for Individuals with Co-Occurring Disorders.

Strategies designed to facilitate integration of mental illness and substance abuse are included in the Department’s Plan (objectives to increase integration of primary and mental health care and to increase effectiveness of collaboration among community mental health providers, state agencies, governmental entities and non-governmental entities). The DMH intends to build on a collaborative initiative with the Mississippi Primary Health Care Association (MPHCA) the Division of Medicaid, the regional community mental health centers and the community health centers, which grew from a 2000 Mental Health and Behavioral Health Regional Summit, sponsored by SAMHSA and HRSA. The Department of Mental Health and Mississippi Primary Healthcare Association have recently had a preliminary discussion regarding re-establishing a structured collaborative effort and inviting partner agencies, such as the Division of Medicaid, the Mississippi State Department of Health, the Department of Human Services and the University of Mississippi Medical Center, to promote communication among specialty system providers and primary care providers. Collaborative efforts will include assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise and the needs of the population for primary and specialty care. Dr. Lydia Weisser, the Department of Mental Health Medical Director, serves as the DMH "content expert” on primary care and behavioral health integration.

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

- DMH participated on the Mississippi Association of Pediatrics Task Force which developed a website that includes a standard referral process for pediatricians to use when referring children to the mental health system.
- A representative from Mississippi State Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth
and the State Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) teams across the state.

- As part of their application to DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The community mental health centers maintain a list of resources to provide medical/dental services.
- The telepsychiatry project being implemented with funding from the Delta Health Alliance by the University of Mississippi Medical Center (UMMC) Department of Psychiatry in 18 counties in the Delta includes plans to utilize mobile technology to integrate basic medical screening into the mental health setting. Plans also include integration of mental health services in a medical setting in at least one site as part of the Delta project. (To be updated)
- The DMH Division of Consumer and Family Affairs is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers.
- The DMH Division of Alzheimer’s Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.
- The DMH Bureau of Alcohol and Drug Abuse continues to work with the Attorney General’s Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner.
- The DMH Bureau of Alcohol and Drug Abuse partners with the MS Department of Rehabilitation Services to fund substance abuse treatment services to individuals in transitional residential programs.
- The DMH Bureau of Alcohol and Drug Abuse works collaboratively with the MS Band of Choctaw Indians and continues to fund prevention services with Choctaw Behavioral Health.

Priority Area #1: Integration of Behavioral Health and Primary Health Care Services (Combined-SMHA/SSA)

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

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

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

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

Priority Area #1: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

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

Strategy: Through a collaborative effort with University of Mississippi Medical Center Child Development Center (UMMCCDC), the DMH Operational Standards require children ages birth to age eighteen (18) be screened within six (6) months of Intake to determine the need for a FASD diagnostic evaluation for identification of primary health and behavioral health problems, and for intervention and treatment by behavioral and primary care providers in the local community. Local MAP Team Coordinators will coordinate the FASD screenings, referring children for diagnosis, and coordinating the provision of services. Case Managers at CMHCs implement interventions identified and assist in accessing needed primary care and behavioral health services.

Performance Indicator: Increased number of FASD screenings conducted by the CMHC and/or MAP Team (2,400); increased number of FASD diagnoses will be reported

Description of Collecting and Measuring Changes in Performance Indicator:
The number of FASD screenings conducted each year in or through the CMHCs and MAP Teams are counted on DMH Division of Children and Youth Monthly Service Report forms and MAP Team Referral reports and entered into a database at the DMH Division of Children and Youth.
Priority Area #1: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

Goal: To educate PHPs, consumers, family members, mental health/substance abuse providers and other workforce professionals on: 1) current issues and trends in alcohol, tobacco and other drug abuse (ATOD) prevention and 2) physical health topics affecting those with SMI, addiction and/or individuals with SMI and a co-occurring substance use disorder, and suicide prevention.

Strategy: Increase staff, consumers and their families understanding of health related topics and the connection between physical and behavioral health; the DMH Bureaus/Divisions will partner with PHPs to plan resource /health fairs; DMH will use web, print, social media, public appearances, and the press to reach the general public, PHPs, mental health and substance abuse providers and other stakeholders in culturally and linguistically appropriate ways; DMH Bureaus and Divisions will provide substance abuse prevention and suicide prevention materials and resources to the MS Choctaw Tribal Schools in grades 7-12 on a quarterly basis; and the Bureau of Alcohol and Drug Abuse will educate PHPs on the prevention of ATOD

Performance Indicator: Educational materials disseminated to PHPs will be tracked; list of MH/SA trainings/participation by PHPs; list of PHP trainings/participation by MH/SA providers; summary of meetings and conferences provided by prevention and mental health staff; and quarterly distribution of materials and resources

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of materials and dates provided will be tracked. All resources and materials uploaded to the DMH website will be updated and tracked.

State Priority #2: Recovery Supports

Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

The DMH Strategic Plan sets forth DMH’s vision of having individuals who receive services have a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. The Council on Quality and Leadership’s Personal Outcome Measures is now the foundation of the Peer Review process. Goal 2 of the DMH Strategic Plan highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis
Mississippi

services, housing, supported employment, long term community supports and other specialized services. Goal 2 also provides a foundation on which DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

**Priority Area #2: Recovery Supports (Combined-SMHA/SSA)**

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

**Strategy:** DMH will continue to refine the peer review/quality assurance process for all community mental health programs and services, including substance abuse services, by utilizing the Personal Outcome Measures (POM) interview protocol to measure outcomes of individuals receiving services. Consumer and family member meaningful involvement will be present on all levels of decision-making in policy development, planning, oversight, and evaluation.

**Performance Indicator:** Improved access and outcomes of services to individuals receiving services will be reported; Number of consumers and family members involved in decision-making activities, peer review/site visits.

**Description of Collecting and Measuring Changes in Performance Indicator:** DMH data.

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**Priority Area #2: Recovery Supports (Combined-SMHA/SSA)**

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

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

**Performance Indicator:** Number of family education groups and number of family workshops and training opportunities to be provided; number of consumers/family members completing the MLA; list of MH/SA trainings/participation; summary of meetings and conferences provided by prevention and mental health staff; quarterly distribution of materials and resources will be tracked; and use and satisfaction of website services will be tracked.

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

Priority Area # 2: Recovery Supports (Combined-SMHA/SSA)

Goal: Establish statewide Medicaid reimbursement for Certified Peer Specialist services.

Strategy: DMH Bureaus and Divisions will hold quarterly meetings with the Division of Medicaid to assess and address current and future Medicaid financing structure for peer and family partner providers.

Performance Indicator: The Certified Peer Specialist service will be reimbursable by Medicaid and increase in workforce

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

Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

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

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

Performance Indicator: DMH will utilize the Council on Quality and Leadership’s (CQL) Personal Outcome Measures (POM) tool to gain information about the level at which service providers are supporting personal outcomes of individuals being served. Increased number of consumers and family members involved in decision-making activities, peer review/site visits

Description of Collecting and Measuring Changes in Performance Indicator: Policies and procedures and number of POM interviews conducted by consumers and family members will be tracked

Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

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

Strategy: Continue to support and fund the development of youth support and leadership teams in CMHC Regions 4 and 7.

Performance Indicator: A regular schedule and agenda of the meetings will be available during the year for CMHC Regions 4 and 7.

Description of Collecting and Measuring Changes in Performance Indicator:
State Priority #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

The Bureau of Alcohol and Drug Abuse and the Bureau of Community Services have an ongoing collaboration to continue to provide treatment services in both mental illness and substance abuse throughout the state. Representation from both bureaus as well as individuals from the 15 community mental health centers serve on the Co-Occurring Disorders Coordinating Committee. This committee functions to identify needs, plans for improvement to services and plans co-occurring activities for individuals diagnosed with co-occurring disorders. The DMH Bureau of Alcohol and Drug Abuse and the Bureau of Community Services participate in joint education and training initiatives and conduct monitoring of programs.

The DMH received funding from the Center for Mental Health Services for the Transformation Transfer Initiative (TTI), one component of which was designed to support continued training of mental health providers in assessment and treatment of co-occurring disorders. Coaching and technical assistance are also being offered to all 15 regional community mental health centers and to four state hospitals following the training. Also, the Bureau of Alcohol and Drug Abuse will continue to allocate funding to the 15 regional community mental health centers earmarked for the provision of mental illness and substance abuse treatment.

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To promote the concepts of recovery and person-centeredness into services for individuals with co-occurring disorders.

Strategy: DMH will provide state-wide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values

Performance Indicator: Improved outcomes of individuals receiving services will be reported; increased access to community based supports will be reported; increased knowledge of staff will be reported; and increased number of positive responses to the Council on Quality and Leadership’s (CQL) 21 Personal Outcome Measures (POM)© (Combined-SMHA/SSA)

Description of Collecting and Measuring Changes in Performance Indicator: POM interviews

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To expand and improve integrated treatment service options for individuals with co-occurring disorders.
Strategy: DMH will review alternative funding to provide additional training on COD; DMH will coordinate and partner with other agencies and organizations to provide and attend COD training; and DMH will continue to monitor and review services provided by the 15 mental health regions and Mississippi State Hospital.

Performance Indicator: Number of COD trainings provided and attended and number of COD programs reviewed

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

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

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

Strategy: Both Bureaus will collaborate in a state-wide conference planned for FY 2012 (MS School for Addiction Professionals), and both Bureaus will continue to monitor and provide technical assistance to co-occurring programs upon request.

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

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

Objectives, Strategies and Performance Indicators for Children with Serious Emotional Disturbance (SED) and their Families

Target or Priority Population to be Served Under the State Plan

Definition of Children with Serious Emotional Disturbance:

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

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

State Priority #1: Integration of Behavioral Health and Primary Care Services

Therapeutic Nursing Services

Registered Nurses provide therapeutic health interventions that are directly related to mental health. In FY 2009, DMH funded funds Region 4 and Region 8 CMHCs to provide therapeutic nursing services in the schools and 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, providing information about and monitoring medications, monitoring sleeping and eating habits, and assisting with health objectives on treatment plans, etc. Region 8 nurses had provided 26,202 contacts, which included nursing assessments, medication monitoring, and physical observations for these children receiving outpatient services through Region 8 CMHC. By March 2010, Region 4 nurses made 10,385 contacts and Region 8 nurses made 20,319 contacts.

Priority Area #1: Integration of Behavioral Health and Primary Care Services

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

Strategy: Continue to fund targeted community mental health regions to provide ongoing therapeutic nursing services to children with SED. 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.

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

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

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.
Mississippi

**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.

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<tbody>
<tr>
<td>Regions w/ DMH Funding for Intensive Therapeutic Nursing Programs</td>
<td>2 regions funded</td>
<td>2 regions funded</td>
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</tr>
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**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

**State Priority #2: Recovery Supports**

**Youth Education/Support Initiatives**

The Mississippi Families as Allies for Children’s Mental Health, Inc. (MS FAA) conducts two Youth Leadership Teams, one located in Jackson called the “Youth Making a Difference” team, which has 20 members and meets monthly during the school year. Meeting topics include conflict resolution, communication skills, alcohol and drug abuse prevention and other skills building activities. MS FAA also coordinates another Youth Leadership Team in the Hattiesburg area of the state, the site of Mississippi’s second System of Care (SOC) initiative, commUNITY cares. The SOC group also formed a Youth Advisory
Council (YAC) to give input to the commUNITY cares project. Members of both groups have attended national SOC grant meetings, the Georgetown Training Institutes and FFCMH annual conferences; they have also made presentations at major state conferences and university social work classes. Both Youth Teams are supported by mental health block grant funds and SOC grant funds and in 2008 became chapters affiliated with the National Youth MOVE, a new CMHS initiative.

Since 2003, MS Families as Allies for Children’s Mental Health, Inc. (MS FAA) has also conducted the Youth Summer Day Camp attended by 15-20 youth with emotional/behavioral challenges who generally experience problems participating successfully in other community day programs. The Youth Summer Camp also welcomes transition-age teens, who may be excluded from other types of camps. MS FAA will continue to provide this summer program, and a similar therapeutic recreation program at the community cares SOC site, with the intent of communicating that the wraparound principle of “no reject, no eject” can be used as a model to broaden summer program opportunities for youth with special needs. This model gives the teens involved a sense of hope and competency. Based on its Youth Camp experiences thus far, MS FAA believes that these less stressful experiences have a beneficial effect on youths’ abilities to cope with their daily challenges at school and in the community and to develop job readiness and independent living skills. Division of Children/Youth staff will continue to support and participate in special projects and activities of MS FAA, including participation on the State Level Case Review/MAP Team and monitoring of respite services and family education programs.

### Priority Area # 2: Recovery Supports

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

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

**Performance Indicator:** Number of family workshops and training opportunities to be provided and/or sponsored by MS FAA (24)

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

**Goal:** 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)

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<tr>
<td># Family Workshops/Training Opportunities Provided/Sponsored</td>
<td>MS FAA provided 20 family workshops/training opportunities with 247 participants; five Parent to Parent (NAMI Basics) classes provided by NAMI-MS</td>
<td>15</td>
<td>15</td>
<td>42</td>
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**Source(s) of Information:** Grant awards/monthly cash requests from MS Families As Allies for Children’s Mental Health, Inc., MS NAMI, and Region 10 CMHC.

**Special Issues:** None

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

**Funding:** Federal and state funds

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**State Priority #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders**

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

As recommended by the Children’s Services Task Force of the MS State Mental Health Planning and Advisory Council, the Department of Mental Health began to explore strategies for increasing efforts to address the needs of youth with co-occurring disorders. For example, the Division of Children and Youth Services and the Bureau of Alcohol and Drug Abuse collaborate to the Alcohol and Drug Studies School included sessions include sessions at the annual Alcohol and Drug Studies School MS School for Addiction Professionals pertinent to co-occurring disorders for youth. The ARK and Sunflower Landing. Beginning in FY 2009, the FASD Coordinator will provide training, information and support to women who may be pregnant or may have children with them while receiving treatment in one of the adult substance abuse residential treatment facilities. Staff in both the DMH Bureau of Alcohol and Drug Abuse and the Division of Children and Youth Services have provided training, information and support to women who may be pregnant or may have children with them while receiving treatment in one of the adult substance abuse residential treatment facilities. A
Mississippi

registered nurse at Fairland, the primary residential Alcohol and Drug treatment facility operated by Region 1 Community Mental Health Center, has been trained and educated by DMH staff to discuss the dangers of drinking while pregnant with the women who are receiving A & D treatment services at Fairland.

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

In the Spring of 2006, COCE facilitated a draft Strategic Plan for Co-occurring Disorders developed in a two and a half day intensive planning session by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded.

In June 2005, the DMH The Division of Children and Youth Services employed a full-time State FASD project director Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS AC-FASD) and co-sponsored an annual FASD Symposium for professionals and families. In April 2007, the FASD Project Director was designated as the State FASD Coordinator to oversee implementation of the State FASD Plan by working in conjunction with the MS Advisory Council on FASD (MS AC-FASD). An FASD contract with Northrop Grumman was initiated in February 2008 to work through the CMHCs and the MAP Teams statewide to screen, diagnose and treat children with FASD.

As of March 2009, The Director of the Prevention Unit in the Bureau of Alcohol and Drug Abuse had been seated on the FASD Task Force. Division of Children and Youth Services staff participated in the 3rd Annual School for Addiction Professionals and provided FASD information for the attendees. A Division of Children and Youth Services staff member continued to participate on the State Prevention Advisory Council, Epidemiological Outcomes Workgroup, Co-occurring Disorders Coordinating Committee and the Underage Drinking Task Force. The Children and Youth Services staff member continues to serve on the planning
committee for the MS School for Addiction Professionals. Substance abuse prevention and/or treatment staff participated in or were consulted as needed by MAP teams. DMH staff continued to make certification visits to the ARK and Sunflower Landing and the CART House, which serve youth with co-occurring disorders.

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders
This goal also addresses Priority Area # 6: Expansion of System of Care for Children and Youth with SED

Goal: To provide funding and support of a System of Care Project that targets children/youth 10-18 years old with co-occurring disorders in three counties in the State.

Strategy: The Division of Children and Youth will continue to provide state match and funding for commUNITY cares, a System of Care Project in Forrest, Lamar, and Marion Counties and will continue to support and participate in commUNITY cares activities and committees.

Performance Indicator: The number of youth served and funding amounts. The number of activities and committees Division of Children and Youth Staff participate in monthly.

Description of Collecting and Measuring Changes in Performance Indicator: DMH Division of Children and Youth Services monthly staff forms, commUNITY cares monthly service reports, grant proposals from continuation of SOC, and Division of Children and Youth program grant files.

As of April 2010, 2003 children ages 0—7 years had been screened for Fetal Alcohol Spectrum Disorders (FASD). Of this number, 186 were identified as needing a full diagnostic evaluation at the FASD diagnostic clinic at the University of Mississippi Medical Center (UMMC) to determine if they had FASD. To date, 23 children have been diagnosed with FASD.

The DMH Bureau of Alcohol and Drug Abuse Services reorganized the statewide conference on co-occurring disorders in FY 2008 and included co-occurring disorders and issues pertaining to adolescents among the topics addressed at the state’s first Alcohol and Drug Studies School. As of March 2009, a Children and Youth Services staff member was designated to continue participation on the Co-occurring Disorders Coordinating Committee. Additionally, The System of Care Project (commUNITY cares), now in its third year of implementation and serving youth with SED and/or co-occurring SED and substance misuse in Forrest and Lamar counties, held several workshops specifically addressing topics such as cognitive behavioral therapy techniques, strengths-based wraparound approaches, and implementation of the Seven Challenges program. The 3rd Annual Mississippi School for Addiction Professionals held January 2010, provided several provides sessions on youth with co-occurring disorders. Additionally the Annual Lookin’ To The Future Conference to be held July 2010 will include a session on youth with co-occurring disorders.
This goal also addresses Priority Area #6: Expansion of System of Care for Children and Youth with SED

**Goal:** The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference planned for FY 2012

**Strategy:** 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

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

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

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

**Population:** Children with serious emotional disturbance

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

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

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

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

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

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

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

**Funding:** Federal and state

Community-based Residential Treatment Programs for adolescents with substance abuse problems provide treatment services for youth who need intensive intervention. These programs have a schedule of activities that include individual counseling, psychotherapeutic
group counseling, self-help groups, family counseling, education services dealing with substance abuse and addiction, educational programs at the appropriate academic levels, vocational counseling services, and recreational and social activities. In 2009, DMH continued to provide funding to three programs, which make available 56 beds for chemical dependence residential treatment for adolescents, some of whom also have a serious emotional disturbance. By March 2010, the three programs had served 66 adolescents with substance abuse problems or co-occurring disorders of substance abuse and SED in a community-based residential treatment. Sunflower Landing served 22 youth (22 of whom had co-occurring disorders), CART House served 26 youth (16 of whom had co-occurring disorders, and the ARK served 18 youth, (18 of whom had co-occurring disorders).

**Priority Area # 3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders**

**Goal:** To provide funding to maintain 48 beds in community-based residential treatment services for adolescents with substance abuse problems and co-occurring disorders.

**Strategy:** Division of Children and Youth services will provide funding community-based residential treatment program services and beds for adolescents with substance abuse problems and co-occurring disorders.

**Performance Indicator:** Number of beds available in community-based residential treatment programs for adolescents with substance abuse problems that receive funds from DMH (48)

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

**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 2011.

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

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<tr>
<td># Beds Funded Residential Treatment</td>
<td>56 beds available; 146 youth served</td>
<td>56 beds available; 137 youth served</td>
<td>56 beds available; 102 Youth Served</td>
<td>48 beds available</td>
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Source(s) of Information: Division of Children/Youth Services Residential Monthly Summary Form/Grant Proposals for three community-based residential treatment sites.

Special Issues: None

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

Funding: Federal funds

State Priority #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Prevention/Early Identification and Intervention Services

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

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

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

The DMH also participates in statewide child abuse prevention efforts by having a representative on the State Board for the Children’s Trust Fund. This fund is drawn from $1.00 fees on each birth certificate and other donations. These funds support projects across the state and provide financial assistance for direct services to prevent child abuse and neglect and to promote a system of services, laws, practices and attitudes that enable families to provide a safe and healthy environment for their children.

### Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

**Goal:** To continue availability of funding for two prevention/specialized early intervention programs.

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

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

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

---

**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 two 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.)
Prevention/Early Intervention–Funded Program

<table>
<thead>
<tr>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 programs funded</td>
<td>2 programs funded</td>
<td>2 programs funded</td>
<td>2 programs funded</td>
</tr>
</tbody>
</table>

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

Special Issues: None

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

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

Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: 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 with emphasis on those children who screen positive for prenatal exposure to alcohol.

Strategy: 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.

Performance Indicator: DMH Division of Children and Youth Services staff will provide technical assistance to service providers on developing mental health services for children under six years of age.

Description of Collecting and Measuring Changes in Performance Indicator: DMH Division of Children and Youth Services monthly staffing report forms.
available to serve children with SED under the age of six years with emphasis on those children who screen positive for prenatal exposure to alcohol.

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

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

**Brief Name:** Early intervention technical assistance

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

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

**Source(s) of Information:** DMH Division of Children and Youth Services monthly staffing report forms.

**Special Issues:** None

**Significance:** The DMH Division of Children and Youth Services encourages and supports programs that include services to identify and intervene with children under the age of six with a serious emotional disturbance including those children who screen positive for prenatal exposure to alcohol to identify problems and intervene as early as possible.

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

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**School-Based General Outpatient Services**

Current *DMH Minimum Operational Standards* require all CMHCs to offer and if accepted, maintain interagency agreements with each local school district in their region, which outline the provision of school-based services to be provided by the CMHCs.

**Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED**

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

**Strategy:** Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families. The DMH *Minimum Operational Standards* require that each CMHC offer school-based outpatient therapy to each school district in their region.

**Performance Indicator:** 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).

**Description of Collecting and Measuring Changes in Performance Indicator:**
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).

<table>
<thead>
<tr>
<th>PI Data Table C1.6</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of School-based Outpatient Services (Offered to schools)</td>
<td>Offered by 15 CMHC Regions; 715 school-based sites (FY data spans two school years).</td>
<td>Offered by 15 CMHC Regions</td>
<td>Offered by 15 CMHC Regions</td>
<td>Offered by 15 CMHC Regions</td>
</tr>
</tbody>
</table>

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: 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

Respite Services are planned temporary services provided for a period of time ranging from a few hours within a 24-hour period, to an overnight or weekend stay. Ideally, respite services may be provided in-home or out-of-home by trained respite workers or counselors, as community-based residential or nonresidential services. 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. Mississippi Families As Allies for Children’s Mental Health, Inc. (MS FAA)
provides respite services and is the administrator for training for respite program. In FY 2009, Mississippi Families As Allies for Children’s Mental Health, Inc. had provided training to 43 respite providers and reported serving 140 youth. MS FAA reported 62 respite providers statewide. Harden House had provided respite training to 66 respite providers and reported serving 272 youth. Harden House reported 177 respite providers available statewide. By March 2010, MS FAA provided training to 43 respite providers (20 of which were new) and reported serving 80 youth. Of the 43 respite providers, MS FAA reported 26 providers available statewide—DMH also continued to provide funding to Harden House for respite. Harden House provided training to 193 providers (16 of which were new) and reported serving 121 youth as of March 30, 2010. Harden House reported 193 respite providers statewide.

### Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

**Strategy:** DMH will continue to fund two providers to support the implementation of respite services.

**Performance Indicator:** The number of respite providers available during the year

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

---

<table>
<thead>
<tr>
<th>PI Data Table C1.9</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># New Respite Providers Trained</td>
<td>52 respite providers trained by MS FAA (of which 20 were new); Harden House trained</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
### Mississippi

<table>
<thead>
<tr>
<th># Respite Providers Available</th>
<th>50</th>
<th>75</th>
</tr>
</thead>
</table>

25 respite providers (of which 25 were new)

MSFAA had 97 available providers; Harden House had 202 available providers

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

#### Special Issues:
None

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

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

### Housing

#### Community-Based Residential Treatment Services

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

Therapeutic Foster Care (TFC) Services continue to be an important community-based component of the Ideal System Model, particularly for children with serious emotional disturbance in the custody of the Department of Human Services. The model utilized in Mississippi employs trained therapeutic foster parents with only one child or youth with SED placed in each home. TFC provides the child with the special attention he/she needs to adapt to a completely different home environment. The major barrier in expanding these homes is the difficulty in finding families to serve the increasingly difficult-to-serve children who need foster care. These children include, but are not limited to, children/youth who demonstrate severe emotional/mental disorders, may have sexually reactive disorders, oppositional-defiant disorders, conduct disorders, may be delusional, and/or, at times, may be suicidal. As of March 2009, DMH continued to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. Additional youth are served in therapeutic foster care funded by other agencies, including the Department of Human Services. In FY 2009, DMH Division of Children and Youth staff continued to make available technical assistance to existing therapeutic foster care programs and/or to other programs seeking DMH certification to support provision of therapeutic foster care services that meet DMH Minimum Standards.
Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

**Strategy:** 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.

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

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

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

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

Population: Children with serious emotional disturbance

Criterion: Comprehensive, community-based mental health system.

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

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

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

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

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

Action Plan: DMH will continue to provide funding to the evidence-based therapeutic foster care program operated by Catholic Charities, Inc. The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by DMH. In FY 2009, visits to provide technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages in Jackson, Methodist Children’s Ministries, Mississippi Children’s Home Services in Jackson and on the Gulf Coast, Stepping Stones, Catholic Charities, and Harden House. As of May 2010, technical assistance regarding program management as well as visits for the purpose of program re-certification had been provided to Youth Villages and Mississippi Children’s Home Services.

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

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children with SED served who received therapeutic foster care services*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2012-2013 Target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>.11</td>
<td>.07</td>
<td>.07</td>
<td>.07</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Numerator: Number Receiving Therapeutic Foster Care Services*

| | (1) | (2) | (3) | (4) |
| Number | 23* | 22 | 22 | 22 |

Denominator: Number of children with

| | (1) | (2) | (3) | (4) |
| Number | 21,000 | 31,488 | 28,500 | 30,000 |
Therapeutic Group Homes are another major community-based residential service component of the ideal system of care. The primary mission of therapeutic group homes is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in therapeutic group homes are individuals who need intensive treatment in a community-based residential setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a therapeutic group home is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

Strategy: DMH will continue to provide funding to support therapeutic group homes.

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

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

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)
Mississippi

<table>
<thead>
<tr>
<th>PI Data Table C1.11</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Funded Therapeutic Group Homes</td>
<td>Funding for support of 9 homes was allocated; 219 children served through homes with DMH funding support; An additional 257 youth served through homes certified, but not funded by DMH</td>
<td>Nine</td>
<td>Nine</td>
<td>Nine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

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 2010, DMH certified twelve 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.

National Outcome Measure: Client Perception of Care – Outcomes

Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: To improve the outcomes of community-based mental health services

Strategy: DMH will work with the University of Mississippi Medical Center (UMMC) 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 beginning with the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions.

Performance Indicator: Percentage of parents/caregivers who respond positively on items in the outcomes domain of the Youth Services Survey for Families (YSS-F)

Description of Collecting and Measuring Changes in Performance Indicator: 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).

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 positively on 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. Since FY 2007, the DMH has been working with the University of Mississippi Medical Center (UMMC) 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 beginning with the 2009 survey 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:** 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) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); 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)**

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2012-2013 Target</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>% Reporting Positively about Outcomes for Children</td>
<td>69%</td>
<td>68%</td>
<td>67%</td>
</tr>
<tr>
<td>Numerator</td>
<td>514 positive responses</td>
<td>366</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>742 responses</td>
<td>540</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Mississippi

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

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Target</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2012-2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Indicator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. % Reporting Positively about Access</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>667 positive responses</td>
<td>477 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>742 responses</td>
<td>535 responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. % Reporting Positively about General Satisfaction</td>
<td>87%</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>651 positive responses</td>
<td>481 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>745 responses</td>
<td>542 responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. % Reporting Positively about Outcomes for Children</td>
<td>69%</td>
<td>68%</td>
<td>67%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>514 positive</td>
<td>369 positive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### National Outcome Measure: Increased Stability in Housing (URS Table 15); Percent of Youth Reported to be Homeless/in Shelters

<table>
<thead>
<tr>
<th></th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. % Reporting on Participation in Treatment Planning for their Children</strong></td>
<td>662 positive responses</td>
<td>742 responses</td>
</tr>
<tr>
<td></td>
<td>480 positive responses</td>
<td>540 responses</td>
</tr>
<tr>
<td><strong>5. % Reporting High Cultural Sensitivity of Staff (optional)</strong></td>
<td>701 positive responses</td>
<td>744 responses</td>
</tr>
<tr>
<td></td>
<td>510 positive responses</td>
<td>540 responses</td>
</tr>
</tbody>
</table>

### Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

**Strategy:** DMH will continue to provide funding and support for two specialized programs serving homeless children/youth with SED who are homeless/potentially homeless due to domestic violence or abuse/neglect.

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

**Description of Collecting and Measuring Changes in Performance Indicator:**
Mississippi

<table>
<thead>
<tr>
<th>Division of Children/Youth Services Program grant reports</th>
<th>And DMH reported data through aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 15: Living Situation Profile</th>
</tr>
</thead>
</table>

**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 two programs that are specialized as they provide outreach and/or a safe place for homeless women and their children and homeless children who have been removed from their homes due to abuse/neglect. Therefore, the percentage of youth who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of children served by these specialized programs occur. DMH is continuing work 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 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.

**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
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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.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of youth reported homeless/in shelters</td>
<td>.2%</td>
<td>.49%</td>
<td>.2%</td>
<td>.36%</td>
<td></td>
</tr>
<tr>
<td>Numerator: # youth reported homeless/in shelters by DMH</td>
<td>63</td>
<td>162</td>
<td>81</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>certified/funded providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: # All youth reported with living situations</td>
<td>29,622</td>
<td>32,997</td>
<td>30,825</td>
<td>31,476</td>
<td></td>
</tr>
<tr>
<td>by DMH certified/funded providers, excluding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Situation Not Available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mental Health Case Management Services

Target Population: The following children/youth with serious emotional disturbances must be evaluated for the need for case management and provided with case management if needed,
based on evaluation, unless the service has been rejected in writing by the parent(s)/legal guardian(s):

- Children/youth with SED who receive substantial public assistance (defined as Medicaid);
- Children/youth with SED who are receiving intensive crisis intervention services; and,
- Children/youth referred to the CMHC after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks for referral for CMHC services).

**Model of Case Management**

Case Management within Mississippi’s service system for children with serious emotional disturbance is key to access, linkage and coordination of services across the system of care (Stroul and Friedman, 1986). Case management facilitates delivery of and movement among all services in the System of Care Ideal System Model. Within a conceptual framework of interagency collaboration and cooperation, functions of local case managers include: assessment of needs and resources to address those needs; planning for individual children and families, including identification of existing resources and/or constraints in implementing service plans; monitoring of progress of the child/family in relation to the service plan; linkage of services within and across child service agencies; facilitating access to services; and, addressing internal or external constraints on achieving goals/objectives of the service plan.

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

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

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

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

**Crisis Intervention** is therapeutic engagement at a time of internal or external turmoil in a child’s life, with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and/or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.
In FY 2010, CMHC Regions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13 and 14 had been certified by DMH to provide school-based case management services.

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

In FY 2010, Regions 1, 4, 5, 10, 13, and 15 were approved for the provision of MIMS for children and youth services.

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

**Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED**

**Goal:** 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.

**Strategy:** Evaluation services will be provided 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.

**Performance Indicator:** Number of children with serious emotional disturbances who receive case management services (15,000)

**Description of Collecting and Measuring Changes in Performance Indicator:** Compliance will be monitored through the established on-site review/monitoring process.
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 (14,000)

<table>
<thead>
<tr>
<th>PI Data Table C1.14</th>
<th>FY 2008 (Actual)</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># SED Receiving Case Management</td>
<td>14,995</td>
<td>14,666</td>
<td>15,181</td>
<td>14,000</td>
<td>26,250</td>
</tr>
</tbody>
</table>

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, 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

Community-Based Emergency Response/Crisis Intervention

The major service components available through Hope Haven, a comprehensive crisis intervention program, include crisis intervention, child and family support, and outpatient services. Hope Haven also makes services available to youth who are homeless/runaway. A second model program funded by DMH and operated in Region 7, Community Counseling Services, serves seven counties (most of which are predominately rural) in the east-central part of the state. This program includes a crisis line specifically for children’s services available
Mississippi

across all seven counties, with linkages to other appropriate services. For children/youth in need of more specialized and intensive intervention, this CMHC focuses on two counties in which an array of specialized crisis services are made available through mobile crisis, intensive in-home therapeutic intervention and extended follow-up after the first four to six weeks. Both comprehensive crisis programs utilize a 24-hour crisis hotline with mobile intensive intervention, enabling services to be provided quickly and efficiently at the youth’s home. In FY 2000, Pine Belt Mental Healthcare Resources (Region 12 CMHC) began receiving state funds for operation of a third comprehensive crisis intervention/emergency response program. This program Pine Belt Mental Healthcare Resources provides community-based crisis response services that are available on a 24-hour basis and an emergency on-call team both during and after work hours to act as a single point of entry into the program for two counties (Forrest and Jones) in the region. Additionally, since FY 2001 a fourth Another comprehensive crisis program, operated by Region 8 CMHC, has received DMH funding. As noted previously, Region 8 CMHC became a partner in the SAMHSA/CMHS Local System of Care grant project at the beginning of the fifth year of the six-year grant cycle, allowing for linkage to their model of crisis intervention services. In FY 2005, Reallocated funding became available for development of a fifth comprehensive crisis service program in Region 4 (Timber Hills Mental Health

Integration of Wraparound in Comprehensive Crisis Intervention Programs

All five non-profit providers of comprehensive crisis intervention programs are affiliated with their local Making a Plan (MAP) teams. The Department of Mental Health will continue to support expansion of crisis services for children, with the goal of establishing a statewide network of crisis management services.

Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Goal: 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.

Strategy: DMH will continue 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.

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

Description of Collecting and Measuring Changes in Performance Indicator: Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for four comprehensive crisis response programs.

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)

<table>
<thead>
<tr>
<th>PI Data Table C1.16</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Funded Crisis Response Programs</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

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

Special Issues: None

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

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

In FY 2009, DMH continued to provide funding for five specialized outpatient intensive crisis intervention projects: Region 3 CMHC had served 227 youth; Region 13 had served 301 youth; Region 15 had served 45 youth; Gulf Coast Women’s Center had served 44 youth; and, Mississippi Families As Allies for Children’s Mental Health, Inc. had served 283 youth. By March 2010, Region 3 CMHC had served 100 youth; Region 13 had served 194 youth; Region 15 had served 67 youth; Gulf Coast Women’s Center had served 70 youth; and, Mississippi Families As Allies for Children’s Mental Health, Inc. had served 130 youth.

Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
**Goal:** To continue specialized outpatient intensive crisis intervention capabilities of five projects.

**Strategy:** DMH will continue funding specialized outpatient intensive crisis projects (5)

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

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

**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)

<table>
<thead>
<tr>
<th>PI Data Table C1.17</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Funded Intensive Crisis Intervention Projects</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

**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

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

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

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

Pre-evaluation Screening and Civil Commitment Services, available through all 15 CMHCs, have as a major purpose to reduce the number of inappropriate admissions to the state psychiatric facilities and to ensure that community-based alternative services are available. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for commitment to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals (applies to youth age 14 years and over). The civil commitment process requires that the local CMHC conduct a pre-evaluation screening for the Chancery Court and the Youth Court to use to determine if the commitment process (including examination for inpatient or outpatient commitment) should continue. The pre-evaluation screener also provides useful information about available community services for the Court’s consideration, if alternatives to inpatient commitment are appropriate. If the court determines there is a need to continue with the involuntary commitment process, the youth is evaluated by two physicians or by one licensed physician and one licensed and certified psychologist. The commitment examination may also be conducted by one licensed physician and a nurse practitioner or a physician’s assistant who are independent from and not under the supervision of the other physician conducting the examination. The commitment examination is to determine if commitment should be made, either for inpatient or outpatient services.

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

**Acute Inpatient Services**

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

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

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

**Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependence Residential Treatment Services for Children and Adolescents** all provide needed community-based alternatives to hospitalization and/or other out-of-home or out-of-state treatment for children with serious emotional disturbance.

**Other Activities Leading to Reduction of Hospitalization**

MAP Teams target children/youth with serious emotional disturbance who may be placed inappropriately out-of-home, are at immediate risk of being placed out-of-home or who may be returning to the community from inpatient/residential care. Currently, there are 37 MAP Teams statewide. The State Level Case Review/MAP Team reviews cases concerning children/youth demonstrating emotional/behavioral problems for whom adequate treatment cannot be found at
the county or local level and for whom no one state agency has been able to secure all the necessary services through its own resources. This state-level team provides another avenue for preventing or reducing hospitalization for youth with more complex or intensive treatment needs who are most at risk for out-of-home placement. As mentioned, the MS Department of Human Services (DHS), which oversees child custody, instructs appropriate staff in its state and local offices that a MAP team review and recommendation may be made prior to authorization of a therapeutic placement by DHS and prior to referral to the State-level Interagency Case Review Team. DHS also direct staff that they should refer children in residential treatment to MAP teams in advance of discharge to determine a wraparound support services plan needed by the child and caregiver(s) to maintain them in the community. Cooperative efforts between the Department of Mental Health and the Division of Medicaid described previously in the section on Other Systems Development Initiatives will enhance development of the system of care.

**Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED**

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

**Strategy:** DMH will implement planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization and to provide evidence-based treatment.

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

**Description of Collecting and Measuring Changes in Performance Indicator:** Uniform Reporting System (URS) tables, including URS Table 20 (Rate of Civil Readmission to State Inpatient Psychiatric Facilities within 30 days and 180 days)

---

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

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health services

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

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

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

**Special Issues:** DMH is continuing work on development of the data system to support collection of information for the National Outcome Measures on readmissions to state psychiatric inpatient facilities with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement project. Data was reported through the
Uniform Reporting System (URS) tables. 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:** CMHCs conduct pre-evaluation screening for civil commitment that is considered by courts in determining the need for further examination for and proceeding with civil commitment to the state psychiatric hospitals. Provision of more timely, county-specific data to CMHCs on individuals they screened who were subsequently readmitted will facilitate collaborative efforts to increase continuity of care across hospital and community services settings and increase focus on the provision of community-based services that prevent rehospitalization.

**Action Plan:** The Department of Mental Health will implement planning and service initiatives described in the State Plan to provide community-based alternatives to hospitalization and rehospitalization and to provide evidence-based treatment.

**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)**

<p>| | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2012-2013 Target</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>---------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>1. Decreased Rate of Civil Readmissions to state hospitals within 30 days</td>
<td>.25%</td>
<td>.8%</td>
<td>.77%</td>
<td>.5%</td>
</tr>
<tr>
<td>Numerator: Number of civil readmissions to any state hospital within 30 days</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Denominator: Total number of civil discharges in the year</td>
<td>402</td>
<td>375</td>
<td>387</td>
<td>388</td>
</tr>
<tr>
<td>2. Decreased Rate of Civil Readmissions to state hospitals within 180 days</td>
<td>5.47%</td>
<td>5.1%</td>
<td>5.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Numerator: Number of civil readmissions to any state hospital within 180 days</td>
<td>22</td>
<td>19</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Denominator: Total number of civil</td>
<td>402</td>
<td>390</td>
<td>387</td>
<td>396</td>
</tr>
</tbody>
</table>
Private Resources

(To be updated)

Outpatient mental health services are also available through licensed practitioners in the private sector, whose scope of practice and services are regulated by their respective licensure boards/agencies and payors of their services (insurance programs, Medicaid, etc.). The Department of Health, which collects data on private psychiatric facilities it licenses, reports 242 licensed and/or CON approved inpatient beds in FY 2009 for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units). The MS Department of Mental Health does not collect data from inpatient facilities in the private sector; that information is maintained by the MS State Department of Health, which licenses those facilities.

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.

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).

Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

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

Performance Indicator: The total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance

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

<table>
<thead>
<tr>
<th>PI Data Table C2.1</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2012-2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td># SED Served</td>
<td>29,269</td>
<td>30,199</td>
<td>31,488</td>
<td>28,500</td>
<td>52,500</td>
</tr>
</tbody>
</table>

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, 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, 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.
Mississippi

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)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) Actual</th>
<th>(2) Actual</th>
<th>(3) Target</th>
<th>(4) Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total persons under 18 years served in public mental health system*</td>
<td>31,821*</td>
<td>38,060</td>
<td>30,000</td>
<td>56,000</td>
</tr>
</tbody>
</table>

*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.

The Division of Children and Youth Services targets many of its outreach efforts to school settings through provision of educational materials and presentations. A major area of growth in the system of care has been the development through community mental health centers of school-based outpatient sites and day treatment statewide, which is also the primary strategy for increasing accessibility of services for youth in rural areas. Objectives related to expanding school-based community mental health services are located under Criterion 1 and Criterion 4.

Representatives of the MDE are participants in state-level interagency groups described previously in this section, and local school district representatives are participants on local Making a Plan teams. Community mental health centers also provide training on children’s mental health services to local teachers.

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

Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

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

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

**Description of Collecting and Measuring Changes in Performance Indicator:**
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.

**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 (273 in 2009) 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.
**Mississippi**

**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).

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2012-2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Indicator</strong></td>
<td>% age of Families of children/adolescents reporting improvement in child’s school attendance</td>
<td>41%</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Number of families of children/adolescents reporting improvement in child’s school attendance (both new and continuing clients)</td>
<td>158</td>
<td>142</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> Total number (including Not Available) (new and continuing clients combined)</td>
<td>385</td>
<td>376</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outreach to and Services for Youth/Families Who Are Homeless**

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

Similarly, the Gulf Coast Women’s Center, which operates a crisis intervention program for children and families (with funding from the DMH) as a component of a domestic violence program, provides outreach to homeless or potentially homeless women and children. In addition, this program also provides care coordination services such as making referrals, securing housing, medical/dental care, and educational services to children and youth with serious emotional disturbances or youth at risk for emotional illness entering the center. In FY 2003, the Gulf Coast Women’s Center began receiving PATH grant funds (federal grant for homeless individuals with mental illness) to address the needs of the women served by the center. (See Criterion #4, Adult Services Plan). In FY 2009, the Gulf Coast Women’s Center reported having served 71 youth, 60 of whom were children with SED or at risk for emotional illness. By March 2010, Gulf Coast Women’s Center had served 70 children with SED or at risk for emotional illness. These children were served in an emergency homeless shelter setting that is specific to domestic violence.

Beginning in FY 2000, Funds were made available to Region 13 CMHC (Gulf Coast Mental Health Center) to provide intensive crisis intervention and support services with an emergency shelter for abused/neglected children/youth and training to staff of the shelter. Gulf Coast Mental Health Center, provides consultation and in-service training to the shelter staff, crisis intervention available on a 24-hour basis, individual, group and family therapy to the children admitted to the shelter. In FY 2009, Region 13 had provided services to 294 children from the local shelter for abused/neglected children, all of whom were enrolled in the services at Region 13 and had a serious emotional disturbance. By March 2010, funding continued to be provided to Region 13 to support services to a local shelter for abused/neglected children that provided services to 70 children.

**Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED**

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

**Strategy:** DMH will continue to provide 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.

**Performance Indicator:** The number of children served through this specialized program (100)

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

<table>
<thead>
<tr>
<th>PI Data Table C4.2</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Children in Domestic Violence Situation Served</td>
<td>71</td>
<td>125</td>
<td>100</td>
<td>175</td>
</tr>
</tbody>
</table>

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

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

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

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

Funding: Federal

Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

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

Performance Indicator: The number of children served through this specialized...
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 (200)

<table>
<thead>
<tr>
<th>PI Data Table C4.3</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Abused/Neglected Children Served</td>
<td>294</td>
<td>293</td>
<td>200</td>
<td>437</td>
</tr>
</tbody>
</table>

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 at 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

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

Definition of areas of the state considered “rural”

In its continued efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas, the Department of Mental Health will use the new definition of “rural,” based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:
“ Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)” are classified as “rural.” More specifically, the Census Bureau “delineates UA and UC boundaries to encompass densely settled territory, which consists of:

· Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
· Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are “split” between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural.”

**Emphasis on School-Based Services:** Key to the Department of Mental Health’s approach to increasing the accessibility of children’s mental health services in rural areas has been expansion of school-based services. For the past few years, Individual, group therapy, family therapy, and school-based day treatment programs have become available through an increasing number of school districts through school-based CMHC therapists. Case managers facilitate significant outreach efforts in rural communities across the state by building communication between school and home and across other community services. (See objectives on school-based outpatient and day treatment services and on case management services, under Criterion 1.)

Since much of Mississippi remains rural, using the school as a base for mental health service delivery is pivotal in facilitating access to services by many youth and families. Providing school-based services also helps address the problem of transportation that exists in rural and other parts of the state. Linkages with schools, which have continued to expand over the last several years, have been received positively by both families and school staff across the state. School district personnel have demonstrated significant willingness to promote accessibility to mental health services at school sites. Technical assistance regarding strategies for expanding and gaining access to services will continue to be made available, upon request, by DMH Division of Children and Youth Services staff as each CMHC region is visited and through specific training sessions/workshops, and activities facilitated by the Division. i.e., case management training, crisis management training and financing strategies.

**Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED**

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

**Strategy:** DMH Division of Children and Youth Services will continue to provide technical assistance regarding the availability of and access to school-based services across CMHC regions.

**Performance Indicator:** Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools.
**Description of Collecting and Measuring Changes in Performance Indicator: Monthly Division Activities Report**

**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.

<table>
<thead>
<tr>
<th>PI Data Table C4.4</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Providers Receiving T.A./certification visits</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

**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

**Support for Culturally Competent Services and Workforce Development**

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. In FY 2010, the MCTF became advisory to the Mississippi Transitional Outreach Program (MTOP) targeting transition-aged youth and further described under Criterion 3. Children and youth service providers had the opportunity to participate in their local CMHC Day of diversity activities in October 2008. In
FY 2009, The 20th Annual Lookin’ to the Future Conference and the Mississippi Conference on Child Welfare offered one session on cultural diversity that addressed issues of a “future with changing faces.” The DMH continues to use the National Coalition Building Institute’s (NCBI) Prejudice Reduction Training Model; Four NCBI and training sessions were conducted to be conducted in CMHC regions and with other service providers. Region 1, 3, Region 8 (Copiah County, Rankin County and Simpson County) and MS FAA in 2009. By April 2010, an NCBI training session was conducted with 60 individuals at MS FAA. Children and youth service providers are encouraged to participate in local CMHC Day of Diversity activities were offered, and children and youth service providers were encouraged to participate. Staff of the Division of Children and Youth Services presented information on cultural competency at the 2009 Mississippi Black Leadership Summit: “Expanding Our Ranks Unleashing Our Power.” Division of Children and Youth staff members have attended workshops on Disparities Among Native Americans, Resources for Spanish-Speaking Communities, National Networks of Libraries of Medicine, Eliminating Mental Health Disparities: Challenges and Opportunities, and Lesbian, Gay, Bisexual and Transgender (LGBT) Youth in MS: Why Day of Silence Matters and African-American and LGBT conference. A Division of Children and Youth staff member has conducted cultural competency training at the local mental health centers, statewide conference, school districts and MYPAC program.

Priority Area # 4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

This goal also addresses Priority Area #6: Expansion of System of Care for Children and Youth with SED

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

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

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

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

**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.
Mississippi

Measure: Count of cultural diversity training sessions presented for children/youth service providers. Source(s) of Information: DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.
Special Issues: None
Significance: DMH requires CMHCs and other DMH-certified programs to offer cultural diversity and/or sensitivity training to employees, in accordance with DMH Minimum Standards.
Funding: Local, state, and federal funds

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Priority Area #4: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

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

Strategy: DMH Division of Children and Youth Staff will continue to provide technical assistance to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.

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

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

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

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

Population: Children with Serious Emotional Disturbance
Criterion: Comprehensive, Community-based mental health system.
Brief name: Availability of technical assistance to DMH-certified programs
Indicator: Continued availability of technical assistance by DMH Division of Children and Youth staff to community mental health service providers to facilitate development/implementation of services and/or programs for children with SED.
Measure: The number and type of technical assistance/support activities made available to CMHCs/other nonprofit service providers.

Sources of Information: Division of Children and Youth staffing report forms
Special Issues: None
Significance: Division of Children/Youth Services will continue to offer technical assistance in the planning, implementing and/or improving services and programs for children and their families. This includes those programs that are identified in the DMH Minimum Standards as core or minimum services that must be available in all CMHC regions.

Funding: Federal, state and local funds

State Priority #5: Interagency Collaboration for Children and Youth with SED

Interagency Collaboration Initiatives:

Facilitation of interagency collaboration and coordination among child and family service agencies and families of children with serious emotional disturbance first developed through earlier federal grant projects, including CASSP initiatives and later also supported by a CMHS Local System of Care Development grant. COMPASS in Hinds and Rankin counties, MS, has been a major focus of the Department, the Division of Children and Youth Services and the Planning Council over time. Interagency collaboration and coordination activities exist at the state level and in various local and regional areas. These activities encompass needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives are:

The Interagency Coordinating Council for Children and Youth (ICCCY): As mentioned under Criterion 1, legislation passed in 2001 was extended by Senate Bill 2991, continuing authorization of a state-level Interagency Coordinating Council for Children and Youth (ICCCY) through 2010. The legislation called for the establishment of an Executive Level The Interagency Coordination Council for Children and Youth, on which the heads of the state agencies for education, health, human services, mental health, rehabilitation services, Medicaid, and the family organization, MS Families As Allies for Children’s Mental Health, Inc. participate on the Interagency Coordinating Council for Children and Youth. The act further established A mid-level Interagency System of Care Council (ISCC) to perform certain functions and advises the Interagency Coordinating Council and to establish a statewide system of local MAP teams. As of March 2010, the DMH Executive Director continued to serve as chairperson of the ICCCY, and the Director of the DMH Division of Children and Youth Services served as chairperson of the ISCC. The members voted on supporting the reauthorization of the Mississippi System of Care legislation in January 2010, since it will sunset June 30, 2010. In March 2010, HB 1529 was passed during the Regular Session and included revisions to expand the ICCCY and ISCC; to revise the Interagency Agreement, and to revise agencies’ policies and procedures to include participation on local MAP Teams.

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

Priority Area #5: Interagency Collaboration for Children and Youth with SED

Goal: 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.

**Strategy:** DMH will continue to be represented on the executive level ICCCY and the mid-level Interagency System of Care Council, in accordance with Senate Bill 2991 House Bill 1529 and continue participation in activities by both Councils to facilitate the development/maintenance of interagency/interorganizational collaboration (at the state, regional and local levels) in development

**Performance Indicator:** Minutes of meetings and related documentation of attendance by DMH representatives at meetings scheduled in FY 2012

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

**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 2011

**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 Interagency Agreement.

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

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

**Funding:** State and federal
State-Level Interagency Case Review MAP Team: The State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, includes representatives of key child service agencies or programs and of families of children with serious emotional disturbance. Agencies represented on Mississippi’s team include the Department of Mental Health; the Department of Human Services; the Office of the Governor, Division of Medicaid; the Attorney General’s Office; the Mississippi Department of Health; the Mississippi Department of Education and the Department of Rehabilitation Services. MS Families As Allies for Children’s Mental Health also has a representative on the team. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children’s mental health services. The team targets those “most difficult to serve” youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home (in-state) or out-of-state placement. The youth reviewed by the team typically have a history of more than one out-of-home psychiatric treatment and appear to have exhausted all available services/resources in the community and/or in the state. There typically have been numerous interruptions in delivery of services across a variety of attempted services due to frequent moves, failure to show for treatment or for unknown reasons. Cases reviewed by the State-Level Interagency Case Review/MAP Team must be referred from the local level. The state-level team identifies what has been tried and the services that have been used; it identifies what is available that may meet needs and what services/supports have not been utilized. The team develops a recommended resource identification and accessibility plan, which might include formal existing services and informal supports; monitors and tracks implementation of the recommended service plan and the status of the child/youth; and, uses information about the availability of needed services, success of services, and other pertinent information in planning efforts. As local, community-level Making a Plan (MAP) teams continue to be developed in local community mental health regions, linkages with the State-Level Interagency Case Review/MAP Team facilitate assistance to local MAP teams as needed. By March 2010, the State Level Case Review Team reviewed 14 cases of youth diagnosed with SED and at risk of being placed in out of state or in state residential care. The Team followed up on six of these youth. The Division Director and another staff member coordinated and facilitated team meetings. Since April 2010, DMH is contracting with a Licensed Clinical Social Worker to coordinate and facilitate the meetings and reviews. Meetings are held the second Thursday of each month to review new cases and/or discuss follow-up to previous cases.

Priority Area # 5: Interagency Collaboration for Children and Youth with SED

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

Strategy: The State-Level Interagency Planning and Case Review Team will continue to meet monthly to review cases and to address the needs of some youth with particularly severe or complex issues.

Performance Indicator: Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases.
Description of Collecting and Measuring Changes in Performance Indicator:
Monthly Division Activities Report and State Level Case Review Team Staffing forms.

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 contract with a Licensed Clinical Social Worker for the facilitation and follow-up of cases reviewed. (Documentation of meetings maintained).
Measure: Continued operation of the State Level team, with meetings on a monthly or as needed basis.

Source(s) of Information: Monthly Division Activities Report and State Level Case Review Team Staffing forms.

Special Issues: None

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

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

The State Level Case Review/MAP Team is facilitated by the Division Director of Children and Youth Services and an assigned Division staff. In FY 2009, The DMH continued to make available funding for the State Level Interagency Case Review/MAP Team to distribute for services for children/youth reviewed by that team and for which funding and/or other resources do not appear accessible at the local level, including youth who reside in counties without MAP Teams. Those youth from communities in which there is no local MAP team with funding will have priority. The state-level team will facilitate a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home. As of March 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 14 targeted children/youth with SED reviewed by the team.

Priority Area #5: Interagency Collaboration for Children and Youth with SED
**Goal:** To provide funding for the State-Level Interagency Case Review/MAP Team to purchase critical services and/or supports identified as needed for targeted children/youth with SED reviewed by the team.

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

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

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

| **Objective:** To provide funding for the State-Level Interagency Case Review/MAP Team to purchase critical services and/or supports identified as needed for targeted children/youth with SED reviewed by the team. |
| **Population:** Children with serious emotional disturbance |
| **Criterion:** Children’s Services |
| **Brief Name:** State-Level interagency team funded |
| **Indicator:** Availability of funding from DMH Division of Children and Youth Services to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team. |
| **Measure:** Availability of funding and the number of children served using this funding for wraparound services |

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

**Special Issues:** None

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

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

**Making A Plan (MAP) Teams**

The MAP teams employ a systems-based wraparound approach in developing a family-centered multi-disciplinary plan, designed to address individual needs and build on the strengths of youth and their families. Key to the team’s functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county human services (family and children’s social services) staff, county youth services (juvenile justice) staff, county health department staff, county rehabilitation services staff and local school staff. Other providers of formal or informal supports, such as youth leaders, ministers or other representatives of children/youth family service organizations in a given community, which vary from team to team, also might participate in the planning or service implementation process. Examples of providers of...
Community supports include youth leaders, ministers or other representatives of children/youth family service organizations in a given community. Thus, implementation of the plan might involve accessing a variety of informal or formal resources in the community and maximizing use of a variety of funding sources.

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

DMH Division of Children and Youth Services coordinates regular meetings with MAP team coordinators to which representatives from the state hospitals child/adolescent units and the Department of Human Services representatives are invited. By March 2010, the Division of Children and Youth Services Director had coordinated three statewide meetings with the local MAP Team Coordinators. The following topics were discussed: the Fetal Alcohol Spectrum Disorders screenings and trainings, the Mississippi System of Care Assessment and Study Report, ICCCY/ISCC activities, MYPAC, case reviews, MAP Team expansion, transitional age youth, and juvenile justice. Technical assistance was provided to MAP Teams in CMHC regions 2, 5, 6, 7, 9, 11, 13 and 15. Technical assistance regarding the expansion of MAP Teams was provided to Regions 2, 6, and 11.

**Priority Area #5: Interagency Collaboration for Children and Youth with SED**

**Goal:** 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.

**Strategy:** DMH Division of Children and Youth Services will continue to provide support and technical assistance to MAP Teams as requested and/or needed.

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

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children’s Services

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

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

Source(s) of Information: Monthly Division Activities Report and minutes of local MAP team meeting.

Special Issues: None

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

Funding: Federal, state and/or local

The wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 15 community mental health regions across the state. 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, with access to flexible funds through the 15 CMHCs and Catholic Charities. By March 2010, One DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. Forty-three counties either had a MAP Team or access to one, and all 40 MAP Teams continued to operate statewide and had accessibility to flexible funds.

Priority Area #5: Interagency Collaboration for Children and Youth with SED

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

Strategy: DMH will continue to fund MAP Teams

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

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

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 38 teams)
Community mental health centers continued to provide information to schools on identification of youth at risk for and with serious emotional disturbances or mental illness and on resources to address the needs of those youth. In FY 2009, informational materials and technical assistance were provided to 822 local schools by community mental health centers. The DMH Division of Children/Youth Services will continue to track the number of schools to which information is made available.

Priority Area # 5: Interagency Collaboration for Children and Youth with SED

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

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

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

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

Population: Children and youth with serious emotional disturbance.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Information/assistance to schools

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

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

Source(s) of Information: Annual State Plan Survey

Special Issues: Tracking of the number of schools to which CMHCs provide educational materials/technical assistance will continue to be a data item on the Annual State Plan Survey in FY 2010. 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

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

Priority Area #5: Interagency Collaboration for Children and Youth with SED

Goal: 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.

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

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

**Population:** Children with serious emotional disturbance

**Criterion:** Children’s Services

**Brief Name:** Participation on interagency committees

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

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

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

**Special Issues:** None

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

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

### Coordination with Other Agencies

Notification of education/training activities offered by the DMH Division of Children and Youth Services will be distributed to programs serving runaway/homeless youth made known to the DMH through other child service agencies (primarily the Department of Human Services). These programs most likely will include emergency shelters approved by the Department of Human Services and/or other appropriate state agencies.

### Priority Area # 5: Interagency Collaboration for Children and Youth with SED

**This goal also addresses Priority Area #6: Expansion of System of Care for Children and Youth with SED**

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

**Strategy:** The DMH Division of Children and Youth will provide information on applicable training/education opportunities to programs serving children/youth with serious emotional disturbance.
**Performance Indicator:** Number of technical assistance activities and/or training offered by DMH staff.

**Description of Collecting and Measuring Changes in Performance Indicator:**
Children and Youth Monthly Staffing Forms

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

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

**Population:** Children with serious emotional disturbance

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

**Brief Name:** Educational opportunities for staff

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

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

**Source(s) of Information:** Children and Youth Monthly Staffing Forms

**Special Issues:** None

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

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

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State Priority #6: Expansion of the System of Care of Children and Youth with SED

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2012-2013 Target</th>
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<td>33%</td>
<td>33%</td>
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<td>Numerator</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Denominator</td>
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Priority Area #6: Expansion of System of Care for Children and Youth with SED

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

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

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

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

**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

**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
Mississippi

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.

Children/Youth Services staff continues to participate regularly in interagency meetings, conferences and other training events that provide opportunities for increasing awareness across the service system of available children’s mental health services. The Division of Children and Youth Services will also continue to disseminate educational materials to the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances. The directory is available through the DMH agency website. As of March 2010, 373 CYS resource directories had been disseminated at conferences or meetings or to individuals, including: Memorial Behavioral Health, Homeless Education Conference, Mississippi Families As Allies, Pre-Evaluation Screening Training, and the School Health Advisory Council.

Priority Area #6: Expansion of System of Care for Children and Youth with SED

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

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

Performance Indicator: Continued production and dissemination of the DMH Division of Children and Youth Resource Directory and other relevant public education material, 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.

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

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.
Mississippi

Brief Name: Information dissemination—general
Indicator: Continued production and dissemination of the DMH Division of Children and Youth Resource Directory and other relevant public education material, made available as needed. Participation in/presentations by DMH Children and Youth Services staff at meetings at which public information is provided, as such opportunities are available.
Measure: Dissemination of directory/other public education material and participation of DMH Children and Youth Services staff in meetings/presentations will be documented. Source(s) of Information: Educational material dissemination documented on monthly staffing forms.

Special Issues: None

Significance: Availability of current information about children’s mental health services through printed material and education by DMH staff is a basic component of ongoing outreach services.

Funding: State funds, CMHS block grant, federal discretionary and other grant funds as available.

Youth Suicide Prevention

The MS Youth Suicide Prevention Council has met at least quarterly since its creation in late 2006. The MS Youth Suicide Prevention Council’s role includes providing leadership and perspective for statewide planning and implementation of prevention and early intervention strategies, including implementation of a Comprehensive State Plan for Youth Suicide Prevention. Representatives on the state level council are from the Mississippi Department of Education, the Mississippi Department of Health, the Jason Foundation, Jackson State University, Mississippi College, the Office of Attorney General, and Catholic Charities, and also include a survivor of a family member who completed suicide, a child psychologist in private practice, Hurricane Katrina-Related Youth Suicide Grant Local and State Project Coordinators, a Community Mental Health Center Children’s Services Coordinator and staff from the Mississippi Department of Mental Health, Division of Children and Youth Services and Division of Disaster Preparedness and Response. In FY 2008, the MS Youth Suicide Prevention Council coordinated the first annual Youth Suicide Prevention Conference, which included workshops on The Role of the Church in Suicide Prevention, Trauma and Suicide, Surviving After a Suicide in the Family, Prevention of Suicide in Schools and on College Campuses, and Risk Factors. In September 2009, a Youth Suicide Prevention Pre-conference Workshop was provided in association with the Mississippi Alliance for School Health Annual Conference. By March 2010, two presentations at workshops/seminars were provided, two safe TALK trainings were conducted and two have been scheduled for June. An ASIST training is scheduled for September.

Priority Area # 6: Expansion of System of Care for Children and Youth with SED

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

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

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

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

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.

Measure: The number of trainings and presentations at workshops/seminars by staff on suicide prevention

<table>
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<th>Mental Health Transformation Indicator: Data Table C1.2</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
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<tbody>
<tr>
<td>Number of suicide awareness, prevention sessions/workshops</td>
<td>1 ASIST Training, 6 safe TALK presentations at workshop/seminars</td>
<td>4 safeTALK; 5 presentations at workshops/ Seminars</td>
<td>Four presentations at workshops and seminars</td>
<td>Six presentations and/or workshops</td>
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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: None


Priority Area #6: Expansion of the System of Care for Children and Youth with SED
Goal: To co-sponsor statewide conferences and/or trainings on the System of Care for providers of mental health services, education services, rehabilitation, human services (child welfare), youth/juvenile justice, physical primary health, and families.

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

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

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

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.

<table>
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<th>PI Data Table C5.1</th>
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<td># Attendance at Statewide Institute or DMH-sponsored conference</td>
<td>Four</td>
<td>Four</td>
<td>Four</td>
<td>Six</td>
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<tr>
<td># of statewide conferences and/or training sessions sponsored or co-sponsored by DMH</td>
<td></td>
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<td></td>
<td></td>
</tr>
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</table>

126
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

 Provision of Evidence-Based Practices

Mississippi Trauma Recovery for Youth (TRY) Project

A grant for the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), began in October, 2003. The Director of the DMH Division of Children and Youth Services served in an advisory role to the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration. Catholic Charities, Inc has led this four-year project in the Jackson, tri-county area and the Gulf Coast to raise the awareness about child trauma and to improve access to services for children and youth who have been traumatized. Through partnership with existing community agencies and programs, the project has developed the TRY Network, which is focused on increasing understanding about child trauma, endorsing the use of best practices in serving traumatized children and youth, and promoting collaboration between systems. The TRY Project is also supporting the validation of a strengths-based assessment tool for use with traumatized children and youth. TRY of Catholic Charities in Jackson, MS, is a member of the National Child Traumatic Stress Network (NCTSN), which works to develop and disseminate effective evidence-based treatments for child trauma; collect data for systematic study; and, help to educate professionals and the public about the effects of trauma on children. The goal of the NCTSN is to improve the quality, effectiveness, provision and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward NCTSN’s overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

The conceptual framework of the project involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practice, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. The project also involves tracking of provision of services and treatment
outcomes over a period of time. The project is designed so that clinical management information can be integrated into the overall quality management program at the direct service and administrative levels. 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. By March 2011, TRY has completed its firsts SPARCS Learning Collaborative, training 28 clinicians and 4 administrators. Participants attended three, two-day Learning Sessions over a one-year span. Beginning in March 2011, TRY began its second SPARCS Learning Collaborative with 24 participants from two CMHCs and the MS Band of Choctaw Indians Behavioral Health. The Learning Collaborative will conclude in October 2011.

**Priority Area #6: Expansion of the System of Care for Children and Youth with SED**

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

**Strategy:** DMH will continue to provide training for additional clinical staff in the evidence-based practice of trauma-focused cognitive behavior therapy through the learning collaborative model.

**Performance Indicator:** The number of additional community mental health services staff who complete training in trauma-focused cognitive behavioral therapy (50)

**Description of Collecting and Measuring Changes in Performance Indicator:** Annual and mid-year information collected from TRY staff at Catholic Charities, Inc.

**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 (50)
# Additional community mental health services staff trained in TF-CBT, SPARCS or other EPBs through Learning Collaboratives

| 78 | 73 | 50 | 90 |

Wraparound Initiatives in Mississippi

Beginning in FY 2010, The Division of Children and Youth Services partnered with the Division of Medicaid, MYPAC Program to begin state-wide training on Wraparound for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. In order to facilitate an equal and effective approach, both Divisions agreed to utilize the University of Maryland’s Innovation’s Institute training model which includes a three-day Wraparound 101 course, one-day Advanced Wraparound and a 12-18 month process for Coach/Supervision Certification. All 15 community mental health centers sent representatives to the first phase of implementation: Wraparound 101. The Coach’s technical assistance meetings began in May 2011 in north Mississippi with central and south trainings scheduled in FY 2012. The Division of Medicaid plans to include Wraparound facilitation in their submission to amend the State Medicaid Plan in FY 2012.

Priority Area # 6: Expansion of the System of Care for Children and Youth with SED

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

Strategy: DMH will continue to provide funds for training of additional CMHC staffing Wraparound 101, Advanced Wraparound and Coach/Supervisor Training utilizing staff from the University of Maryland’s Innovations Institute.

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

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

State Priority #7: Integrated Services for Children and Youth with SED
Adolescent Offender Programs

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

Juvenile Justice Interagency Training

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 the Mississippi Department of Human Services (DHS) to develop and provide training for A Team members in all seven DHS service areas in the state.

Priority Area #7: Integrated Services for Children and Youth with SED

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

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

Performance 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.

Description of Collecting and Measuring Changes in Performance Indicator:
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).

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 (43 in 2009) 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).
**Mississippi**

<table>
<thead>
<tr>
<th>% age of children/adolescents Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)</th>
<th>50</th>
<th>73%</th>
<th>44%</th>
<th>61%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Number of children/adolescents arrested in T1 who were not rearrested in T2 (new and continuing clients combined)</td>
<td>14</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of children/adolescents arrested in T1 (new and continuing clients combined)</td>
<td>28</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

In recent years, the Division of Children and Youth Services, the Division of Adult Community Services and the Division of Alcohol and Drug Abuse have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years.

The Transitional Services Task Force—A task force was formed to better identify and plan to assess needs of youth, age 18 to 25 years. It continued its interagency initiatives in FY 2009 and will continue in FY 2010. The task force began meeting in July 2003, further defining the direction for identifying and serving youth with serious emotional disturbances or mental illness in this age group. This group, Task Force has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14. This has been identified as an the age at which children/youth begin to fall out of the system.

Through learning about the Transitional Outreach program, which is funded by the Department of Mental Health, the group has been able to identify ways to address the needs of the transition-age youth in an intensive case management model that utilizes the wraparound approach. In FY 2005, coordination of the Transitional Services Task Force was assigned to the DMH Division of Children and Youth Services staff member who works specifically with those programs that serve transition-age youth. The Task Force includes representatives from a local mental health center that provides a transitional living program, as well as representatives from the MS Department of Rehabilitation Services, the Office of the Attorney General and the DMH Divisions of Children and Youth Services and Alcohol and Drug Abuse. The group Task Force has reviewed a mission statement, purpose and goals, and focused on preliminary identification...
of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. The group has been able to identify ways to address the needs of the transition-age youth in an intensive case management model that utilizes the wraparound approach. Potential goals discussed included development of a resource/service directory to assist parents and professionals involved with this age group and strategies for increasing collaboration specifically targeting the transition age group.

The work of this Task Force and its members assisted in the development of a successful grant application for a Children’s Mental Health Initiative targeting transition – aged youth. The six-year System of Care grant will provide funds for the implementation of six four additional Transitional Outreach Programs (TOP) across the state.

Additionally, as explained under Criterion #2, changes made in prior years to the definition of children with serious emotional disturbance in this Plan and in the Medicaid Mental Health (CMH) Provider Policy Manual included extending the upper age limit to up to 21 years, while the lower age range for adults with serious mental illness remains at 18 years. This change allows more flexibility in individualization of services for youth 18 to 21 years, including access to services in either the child system or the adult system, depending on the strengths, needs, and preferences of the individual young person.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services of a provider of a transitional living services program that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. Part of Mississippi’s FY-2000 CMHS Block Grant increase was used to provide an additional clinical coordinator to partner with an existing coordinator to facilitate and enhance services across all therapeutic group homes operated by one provider. In FY-2009, there were six transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and two homes operated by Hope Village. Four of the homes received DMH funding support. DMH provides funding to four (4) of the six (6) DMH certified transitional therapeutic group homes (Rowland, Harden House, and two programs operated by Hope Village). By March 2010, DMH certified and continued funding for 4 transitional therapeutic group homes (Rowland, Harden House, and two programs operated by Hope Village). DMH also continued to certify two more transitional therapeutic group homes (PALS and PALS II).

Priority Area #7: Integrated Services for Children and Youth with SED

Goal: 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).

Strategy: DMH will continue funding 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.

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

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

<table>
<thead>
<tr>
<th>PI Data Table C3.5</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Transitional Living Homes/Supported Living Programs Funded</td>
<td>4 transitional living programs; two additional programs were certified, but not funded by DMH</td>
<td>Four transitional living programs</td>
<td>Four transitional living programs</td>
<td>Four transitional living programs</td>
</tr>
</tbody>
</table>

**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

**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
Total Number of Children with Serious Emotional Disturbance

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

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

Prevalence in Mississippi

(Estimates will be revised, pending receipt of updated information from SAMHSA)
As part of the early stages of the planning process under P.L. 99-660, the state based its previous estimates of the size of the population of children and youth with significant mental health needs, including those in need of an array of services, on ranges then available and summarized in the professional literature. Current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating the incidence and prevalence of serious emotional disturbance among children and adolescents. Thus, in the FY 2011 State Plan, Mississippi utilized final methodology for estimating prevalence of serious emotional disturbance among children and adolescents, as published by the (national) Center for Mental Health Services (CMHS) in the July 17, 1998, issue of the Federal Register explained above. Estimates in the FY 2011 State Plan were updated from Uniform Reporting System (URS) Table 1: Estimated number of children and adolescents, age 9-17, with serious emotional disturbances by state, 2009 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
Mississippi

ranges in the 7/17/98 Federal Register. The estimated number of children, ages 9 through 17 years in Mississippi in 2009 is 375,918*. Mississippi remains in the group of states with the highest poverty rate (21.5% age 5-17 in poverty, based on 2008 Federal poverty rates), therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2009 are as follows:

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

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 2011 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 (134,710**), yielding an estimated prevalence of 12,393 in this transition age group.

* Civilian population aged 9 to 17 were created by the NRI using Census data from 2009 for the numbers of persons aged 9 to 17 and 2008 federal poverty rates.

** Calculated by Dr. Barbara Logue, Senior Demographer, MS Institutions of Higher Learning, based on 2000 Census data and 2009 Census estimates.
**Goal:** To include in the State Plan an estimate of the prevalence of serious emotional disturbance among children in the state.

**Strategy:** Utilization of revised estimated prevalence ranges of serious emotional disturbance among children and adolescents (9-17 years of age) in the FY 2011 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. There are limitations to the interpretations of this prevalence estimate.

**Performance Indicator:** Inclusion of prevalence estimates derived using federal methodology in the FY 2011 State Plan.

**Description of Collecting and Measuring Changes in Performance Indicator:**
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 the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.

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

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

**Population:** Children with serious emotional disturbance

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

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

**Indicator:** Utilization of revised estimated prevalence ranges of serious emotional disturbance among children and adolescents (9-17 years of age) in the FY 2011 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 2011 State Plan.

**Source of Information:**
Recommended federal methodology in Federal Register; Small Area Income and Poverty Estimates Program, U.S. Census Bureau, November, 2000; 2000 U.S. Census data; consultation with staff from the Center for Population Studies, University of MS; from the Institutions of Higher Learning (MS State Demographer); and 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

Children’s Community Mental Health Services  
(To be updated)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Grants (CMHS, SSBG)</td>
<td>4,172,380</td>
<td>4,172,380</td>
</tr>
<tr>
<td>State Funds (grants, Medicaid match)</td>
<td>9,501,267</td>
<td>9,501,267</td>
</tr>
<tr>
<td>Healthcare funds (grants, Medicaid match)</td>
<td>1,032,783</td>
<td>1,032,783</td>
</tr>
<tr>
<td>Trf. from CMHCs for Medicaid match</td>
<td>3,816,900</td>
<td>3,816,900</td>
</tr>
<tr>
<td>Local Taxes*</td>
<td>4,128,038</td>
<td>4,128,038</td>
</tr>
<tr>
<td>Local Fees</td>
<td>2,250,000</td>
<td>2,250,000</td>
</tr>
<tr>
<td>Federal Medicaid Reimbursements*</td>
<td>61,033,500</td>
<td>61,033,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85,934,868</strong></td>
<td><strong>85,934,868</strong></td>
</tr>
</tbody>
</table>

*Based on estimated use of funds for children’s services of 45% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

**Staffing**

**Human Resources, CMHCs**

<table>
<thead>
<tr>
<th>POSITION</th>
<th>Total Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychiatrists</td>
<td>29</td>
</tr>
<tr>
<td>2. Other Physicians</td>
<td>7</td>
</tr>
<tr>
<td>3. Psychologists, Ph.D.</td>
<td>11</td>
</tr>
<tr>
<td>4. Staff with Master’s Degree or Above in Field of Psychology</td>
<td>73</td>
</tr>
</tbody>
</table>
Mississippi

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Other Psychologists</td>
<td>14</td>
</tr>
<tr>
<td>6. Social Worker (MSW, Other Master Degree or Above.)</td>
<td>205</td>
</tr>
<tr>
<td>7. Other Social Workers</td>
<td>71</td>
</tr>
<tr>
<td>8. Registered Nurses (AA or Above)</td>
<td>50</td>
</tr>
<tr>
<td>9. Licensed Practical or Vocation Nurses</td>
<td>13</td>
</tr>
<tr>
<td>10. Other Mental Health Professionals (Bachelor Degree or Above)</td>
<td>522</td>
</tr>
<tr>
<td>11. Other Mental Health Workers (Less that Bachelor’s Degree)</td>
<td>46</td>
</tr>
<tr>
<td>12. Physical Health Professionals</td>
<td>11</td>
</tr>
<tr>
<td>13. All Other Staff (clerical, maintenance, etc.)</td>
<td>352</td>
</tr>
<tr>
<td>14. Totals</td>
<td>1404</td>
</tr>
</tbody>
</table>

Mental Health Transformation Activities: Workforce Development

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

Local Infrastructure Development: In FY 2009, The DMH, Division of Children and Youth Services continued to seek opportunities to provide or arrange for technical assistance and training for CMHC and other providers receiving funds through the DMH. Division of Children and Youth Services staff provided and/or facilitated the following training for providers of mental health services for children/youth: “FASD 101,” screening, referrals and assessments; cultural competency and diversity; treatment plan and progress note development; managing aggressive youth in therapeutic group homes; “MAP Team 101” training; youth suicide prevention (ASIST & safeTALK); Annual Mississippi School for Addiction Professionals; KIDS COUNT Conference; MS VR Conference; MS Gulf Coast Suicide Prevention Conference; Youth Suicide Prevention for school safety officers; Annual Lookin’ To The Future Conference; FASD Symposium; MASH Conference; Youth Court Judges and Referees Seminar; and MYPAC Training. By March 2010, Division of Children and Youth Services staff provided and/or facilitated the following training for providers of mental health services for children/youth: “FASD 101,” screening, referrals and assessments; MAP Team 101, expansion and development; Therapeutic Group Home annual training; Annual MS School for Addiction Professionals; KIDS COUNT Conference; treatment plan and progress note development; youth suicide prevention; and, MS System of Care Initiatives.
In FY 2009, the DMH Division of Children and Youth Services sponsored the First Annual Gulf Coast Suicide Prevention Conference (April 2009) and a cultural and linguistic workshop (April 2009 for all providers). In July 2009, DMH continued as a primary sponsor the 21st Annual Lookin’ To the Future and the Mississippi Permanency Partnership Network Conference, conducted by Southern Christian Services. In September 2009, DMH also continued to sponsor the annual Mississippi Alliance for School Health Conference, with a pre-conference focusing on youth suicide prevention. By March 2010, DMH continued to serve as primary sponsor of the Annual Lookin’ To The Future Conference conducted by Southern Christian Services for Children and Youth. DMH also sponsored the Annual KIDS COUNT Conference and 4 WRAP Around Trainings held by the University of Maryland. DMH will continue to sponsor the annual Mississippi Alliance for School Health Conference and the Annual FASD Symposium in September 2010.

Technical assistance to residential treatment providers and state inpatient psychiatric hospitals also will continue to be provided or facilitated by DMH Division of Children and Youth Services staff, as requested/needed. Staff from the psychiatric units at the state hospitals will also continue to be invited to participate in monthly MAP team coordinators’ meetings, at which additional technical assistance is available.

Training of Emergency Health Workers in the Area of Children’s Mental Health

Mental Health Transformation: Practices (NFC Goals 5.3 and 5.4)

Mississippi has allocated part of its increase to the FY 2007 CMHS Block ($52,511) to expand training in the evidence-based practice of trauma-focused cognitive behavioral therapy, building on “lessons learned” through the four-year Mississippi Trauma Recovery for Youth (TRY) project. The first Learning Collaborative effort provided training in the evidence-based practice of trauma-focused cognitive behavior therapy for a core group of mental health therapists and their supervisors at Gulf Coast Mental Health Center (Region 13 CMHC) from October 2006 through April 2007.

Funding from the FY 2008 CMHS Block Grant award will continue to be provided to Catholic Charities, Inc. to continue and expand the training to include additional clinical staff in community mental health programs. This national collaborative learning model has become a part of an approach for implementing an evidence-based practice at the community level in Mississippi, beginning with implementation of trauma-informed services for youth.

In the summer 2010, 45 clinicians at Pine Belt Mental Healthcare Resources were trained in TF-CBT. 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 had been attended by 78 therapists and clinicians and by Learning Session II, had resulted in 121 children/youth receiving trauma-focused cognitive behavior therapy (TF-CBT). Each Collaborative involves supervisory staff in three, two-day Learning Sessions and in monthly phone consultations at intervals over a 12-month period to provide training and disseminate and sustain the evidence-based practice of TF-CBT. By March 2010, the Mississippi Trauma Recovery for Youth (TRY) Project began a Learning Collaborative for Structured Psychotherapy
for Adolescents Responding to Chronic Stress (SPARCS) with four CMHC regions and staff from Specialized Treatment Facility.

**Initiatives Related to Children in Crisis in Schools**

Additionally, as described under Criterion #1, Region 3 CMHC receives a specialized crisis intervention grant that helps support therapists in schools in that region. Also, Region 8 CMHC, through funding from DMH, provides therapeutic nurses in all four counties it serves and additionally, provides crisis case managers in Rankin County.

**Other Initiatives for Training of Emergency Services Personnel**

The DMH Division of Children and Youth Services will continue collaboration with the DMH Division of Community Services, which coordinates the Law Enforcement Task Force, to review the curricula used for law enforcement training for adequacy in addressing issues related to youth who might be encountered in a mental health crisis. Division staff will participate and/or support other efforts of the task force to assist or advise other agencies with responsibility for training emergency services personnel as requested. (The Department of Mental Health Minimum Standards for adults require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH.) Information on training offered by local providers regarding crisis management/intervention will continue to be reviewed.

**Case Manager Training**

*Note to Reader: The following section is deleted here, but is addressed in a section that combines objectives that pertain to both children’s and adults’ services.*

In FY 2009, seven case management orientation sessions had been conducted and 180 case managers were trained. Training and technical assistance for new case managers, as well as review sessions for existing case management staff, will continue to be available from DMH Division of Children and Youth staff, upon request from CMHCs. Technical assistance, orientation and support for case managers are also available at the local level through existing staff at the CMHCs. By March 2010, two more case management orientation sessions were held, and Division of Children and Youth Services staff participated in both sessions. Additionally, as described in the following section on the certification/licensure program, the Department of Mental Health has also developed a certification program for case managers. DMH is drafting updated *Rules and Regulations for the Case Management Certification Program* and intends to pilot an online self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program; therefore, the following objective is being deleted. Providing the case management training program online will provide cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area.

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**Mental Health Therapist Certification and Licensure Program**
The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master’s level or above mental health staff members who are employed within Mississippi’s state mental health system and who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist Exam and corresponding study guide was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 continuing education (CE) hours of mental health-related training over a two year period in order to meet biennial renewal requirements. (*Note: the Mental Health Therapist licensure level is no longer available to new individuals, effective January 2009; however, individuals who achieved this level prior to its discontinuance are able to maintain it as long as they continue to meet the renewal requirements.)

Licensed Department of Mental Health (DMH) Administrator Program

The Mental Health Administrators program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master’s level or above individuals who hold positions as the top level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Once an individual enters the Program as a Program Participant, he/she must complete a program of Independent Study/Training to obtain licensure. Two Independent Study/Training Options are currently available: Option One successful completion of the Mississippi Certified Public Manager program and a series of written examinations based on Mississippi rules/regulations/standards and Option Two successful completion of the Mississippi Certified Public Manager program and completion of the Department of Mental Health’s leadership development program, Focus. After one of these Independent Study/Training options has been met, Program Participants are issued licensure. Once licensed, each individual is expected to accrue at least 40 contact hours of continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification Professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor’s level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of Provisional Certification and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental
health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, PLACE made a number of changes:

- Began conversion of credentialing information and application forms to a web-based and/or email format. Therefore, PLACE staff no longer track how many application booklets are mailed out.
- Converted the previously required three Mental Health workshops and exams into one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. PLACE provided study materials to applicable programs.
- Changed the Independent Study/Training component for the Licensed DMH Administrator program to offer two options for Program Participants. Within the “exam option,” the requirement was changed from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- Changed the training requirement for the Case Management program from three workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.
- Discontinued requiring CEs to move from provisional to full certification or licensure. CEs are only required to renew.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Licensed DMH Administrator Program and the Case Management Credentialing Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report continuing education hours when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of the number of individuals in the process of pursuing ongoing in-service/training.

**Objective:** To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Licensed DMH Administrator and Case Management Credentialing 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 Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.
Mississippi

**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 Licensed DMH Administrator program; the number of individuals who hold a credential in the Case Management Professional program. (Note: This measure includes individuals whose credentials have lapsed/expired.)

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

**Special Issues:** None

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

**Funding:** State funds

The number of individuals who hold a credential in the Mental Health Therapist program, the number of individuals who are Participants in the Licensed DMH Administrator program, and, the number of individuals who hold a credential in the Case Management Professional Program projected for FY 2011 are indicated in the chart that follows:

<table>
<thead>
<tr>
<th>Credentialing Program</th>
<th>FY-2007 (Actual)</th>
<th>FY-2008 (Actual)</th>
<th>FY-2009 (Actual)</th>
<th>FY-2010 (Target)</th>
<th>FY-2011 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Therapists (all levels)</td>
<td>1,733</td>
<td>1,959</td>
<td>2,161</td>
<td>2,175</td>
<td></td>
</tr>
<tr>
<td>Mental Health Administrators (all levels)</td>
<td>124</td>
<td>122</td>
<td>126</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>Number of individuals in the Case Management Certification Program (Beginning FY-2006)</td>
<td>367</td>
<td>629/758</td>
<td>607</td>
<td>845</td>
<td></td>
</tr>
<tr>
<td>Number of individuals who hold a credential in the Mental Health Therapist Program</td>
<td></td>
<td></td>
<td></td>
<td>1,275</td>
<td></td>
</tr>
</tbody>
</table>
Mental Health Transformation Activity: Workforce Development through Academic Linkages

Academic Linkages at the Local Level continued in FY 2008, with 14 CMHCs and eight nonprofit programs reporting various training linkages pertaining to children’s mental health with state universities and/or state community colleges, as well as private colleges. Areas of training/disciplines represented included: nursing, psychology, social work, psychiatry, (including child psychiatry), sociology, art therapy, social science, community counseling, education, school counseling, rehabilitation counseling, family and human development, public policy and administration, family studies, marriage and family therapy, public health, industrial counseling, educational psychology, criminal justice and human services. Additionally, the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) has integrated the child psychiatry fellowship program at UMMC with Mississippi State Hospital’s Oak Circle Center staff and facilities.

Telepsychiatry Project

The UMMC Department of Psychiatry and Human Behavior 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). 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; they expect to have all community mental health centers in that region connected by the fall of 2010. In addition, the telepsychiatry service linked 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). 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.

Projected Expenditures of Center for Mental Health Services Block Grant Funds for Children’s Community Mental Health Services by Type of Service for FY 2011-2012-2013
## Mississippi

<table>
<thead>
<tr>
<th>Service</th>
<th>Projected Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Crisis Intervention</td>
<td>468,775</td>
</tr>
<tr>
<td>Specialized/Multi-Disciplinary Sexual Abuse Intervention</td>
<td>25,039</td>
</tr>
<tr>
<td>Community Residential</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Group Homes</td>
<td>$225,722</td>
</tr>
<tr>
<td>Therapeutic Foster Care</td>
<td>$30,000</td>
</tr>
<tr>
<td>Crisis Intervention/Response Models</td>
<td>466,192</td>
</tr>
<tr>
<td>Respite</td>
<td>45,741</td>
</tr>
<tr>
<td>Multidisciplinary Assessment &amp; Planning Teams</td>
<td>402,892</td>
</tr>
<tr>
<td>(including State-level Case Review Team)</td>
<td>$357,089</td>
</tr>
<tr>
<td>Therapeutic Nursing Services</td>
<td>90,000</td>
</tr>
<tr>
<td>Peer Monitoring</td>
<td>47,424</td>
</tr>
<tr>
<td>Training/Education/Staff Development</td>
<td>77,511</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$1,549,296</strong></td>
</tr>
</tbody>
</table>

Projected Allocation of FY 2011-2012-2013CMHS Block Grant Funds
For Children’s Services by Region/Provider

<table>
<thead>
<tr>
<th>Providers</th>
<th>Projected Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region One Mental Health Center</td>
<td>$15,357</td>
</tr>
<tr>
<td>P.O. Box 1046</td>
<td></td>
</tr>
<tr>
<td>Clarksdale, MS 38614</td>
<td></td>
</tr>
<tr>
<td>Karen Corley</td>
<td></td>
</tr>
<tr>
<td>Interim Executive Director</td>
<td></td>
</tr>
<tr>
<td>(MAP Team flexible funds)</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Amount</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Communicare</td>
<td>$8,000</td>
</tr>
<tr>
<td>Carole B. Haney, Acting ED</td>
<td></td>
</tr>
<tr>
<td>Region III Mental Health Center</td>
<td>$38,565</td>
</tr>
<tr>
<td>Robert J. Smith, ED</td>
<td></td>
</tr>
<tr>
<td>Timber Hills Mental Health Services</td>
<td>$168,677</td>
</tr>
<tr>
<td>Charlie D. Spearman, ED</td>
<td></td>
</tr>
<tr>
<td>Delta Community Mental Health Services</td>
<td>$10,000</td>
</tr>
<tr>
<td>Richard Duggin, ED</td>
<td></td>
</tr>
<tr>
<td>Life Help</td>
<td>$17,857</td>
</tr>
<tr>
<td>Madolyn Smith, ED</td>
<td></td>
</tr>
<tr>
<td>Community Counseling Services</td>
<td>$89,159</td>
</tr>
<tr>
<td>Jackie Edwards, ED</td>
<td></td>
</tr>
<tr>
<td>Region 8 Mental Health Services</td>
<td>$142,745</td>
</tr>
<tr>
<td>Dave Van, ED</td>
<td></td>
</tr>
<tr>
<td>Weems Community Mental Health Center</td>
<td>$15,357</td>
</tr>
</tbody>
</table>
Mississippi

Meridian, MS 39304
Maurice Kahlmus, Executive Director
(MAP Team flexible funding)

Catholic Charities, Inc., Natchez (Region 11) 10,357
200 N. Congress, Suite 100
Jackson, MS 39201
Greg Patin, Executive Director
(MAP Team flexible funding)

Southwest MS Mental Health Complex 4,000
P.O. Box 768
McComb, MS 39649-0768
Steve Ellis, Ph.D., Executive Director
(MAP Team flexible funding, Pike County)

Pine Belt Mental Healthcare Resources 20,357
P.O. Drawer 1030
Hattiesburg, MS 39401
Jerry Mayo, Executive Director
(MAP Team flexible funding)

Gulf Coast Mental Health Center 43,538
1600 Broad Avenue
Gulfport, MS 39501-3603
Jeffrey L. Bennett, Executive Director
(Intensive Crisis Intervention, MAP Team flexible funding)

Singing River Services 15,357
101-A Industrial Park Road
Lucedale, MS 39452
Sherman Blackwell, II, Executive Director
(MAP Team flexible funding)

Warren-Yazoo Mental Health Services 70,357
P. O. Box 820691
Vicksburg, MS 39182
Steve Roark, Executive Director
(Intensive Case Management and MAP Team flexible funding)

Catholic Charities, Inc. 365,398
200 N. Congress St., Suite 100
Jackson, MS 39201
<table>
<thead>
<tr>
<th>Organization</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gulf Coast Women’s Center</td>
<td>$30,000</td>
</tr>
<tr>
<td>P. O. Box 333</td>
<td>$21,000</td>
</tr>
<tr>
<td>Biloxi, MS 39533</td>
<td></td>
</tr>
<tr>
<td>Sandra Morrison, Director</td>
<td></td>
</tr>
<tr>
<td>(Intensive Crisis Intervention)</td>
<td></td>
</tr>
</tbody>
</table>

| Mississippi Children’s Home Society and CARES Center | 125,722     |
| P.O. Box 1078                                      |             |
| Jackson, MS 39215-1078                             |             |
| Christopher Cherney, CEO                           |             |
| (Therapeutic Group Home)                           |             |

| MS Families As Allies for Children’s Mental Health, Inc. | 221,040     |
| 5166 Keele St., Bldg. A                               | $155,740    |
| 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) |             |

| Southern Christian Services for Children and Youth   | $120,000    |
| 1900 North West St., Suite B                         | $165,739    |
| Jackson, MS 39202                                    |             |
| Sue Cherney, Executive Director                      |             |
| (Mental Health Services for Transitional TGHs and Training) |             |

| Vicksburg Family Development Service                | 25,039      |
| P. O. Box 64                                       | $30,000     |
| Vicksburg, MS 39180                                |             |
| Kay Lee, Director                                  |             |
| (Sexual Abuse Intervention)                        |             |

| 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)                        |             |
Note: A total of $187,722 (5% of the total amended award to be spent on services in FY 2011) will be used by the Mississippi Department of Mental Health for administration. It is projected that $84,231 will be spent for administrative expenses related to children’s community mental health services.

Table C. Mental Health Block Grant Funding for Transformation Activities

<table>
<thead>
<tr>
<th>Transformation Activity</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is MHBG funding used to support this goal? If yes, please check.</td>
<td>If yes, please provide the actual or estimated amount MHBG funding that will be used to support this transformation goal in FY 2011</td>
</tr>
<tr>
<td>Goal 1: Americans understand that mental health is essential to overall health.</td>
<td>X</td>
<td>$466,057</td>
</tr>
<tr>
<td>Goal 2: Mental health care is consumer and family driven.</td>
<td>X</td>
<td>$90,000</td>
</tr>
<tr>
<td>Goal 3: Disparities in mental health services are eliminated.</td>
<td>X</td>
<td>$417,696</td>
</tr>
<tr>
<td>Goal 4: Early mental health screening, assessment, and referral to services are common practice.</td>
<td>X</td>
<td>$107,511</td>
</tr>
<tr>
<td>Goal 5: Excellent mental health care is delivered and programs are evaluated.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Goal 6: Technology is used to access mental health care and information.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal II: Mental health care is consumer and family driven.** Programs and/or services supported with CMHS Block Grant funds that are family driven include respite services ($45,741), which are coordinated and provided through Mississippi Families As Allies for Children’s Mental Health, Inc.; Making a Plan (MAP) Team activities ($402,892), which involve family members in a state-level and local interagency teams that coordinate services and individualized planning for youth with serious emotional disturbances who have complex needs; and, peer review monitoring activities ($17,424), which include family members with professionals in on-site program monitoring. (Note: Peer monitoring also addresses Goal V.)

**Goal III: Disparities in mental health are eliminated.** CMHS Block Grant funds ($90,000) are used to support provision of therapeutic nursing services provided in school-based programs in two community mental health regions. Providing services through school-based sites is a
major strategy in increasing access in rural areas. (Provision of therapeutic nursing services in school-based programs also addresses Goals I and IV.)

**Goal IV:** Early mental health screening, assessment and referral services are common practice. Crisis intervention programs ($266,935) and one sexual abuse intervention program ($25,039) supported with CMHS Block Grant funds (some of which are also school-based) all emphasize early identification, assessment, referral and treatment. CMHS Block Grant funding ($125,722) also supports the provision of community-based residential treatment services for youth with co-occurring disorders of serious emotional disturbance and substance use/abuse.

**Goal V:** Excellent mental health care is delivered and programs are evaluated. CMHS Block Grant funds are used to support implementation of evidence-based practices, including the provision of therapeutic foster care services ($30,000) and training in trauma-focused cognitive behavior therapy ($52,511). Other workforce development activities are supported through CMHS Block Grant funds ($25,000), including a statewide annual conference for children’s mental health service providers. Topics addressed at this conference also relate to other Transformation Goals (e.g., cultural competency training would also address Goal III).

**Note:** Activities that address **Goal I:** Americans understand that mental health is essential to overall health, such as a statewide anti-stigma campaign and a youth suicide prevention initiative, are supported with state and/or other federal funds.

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**Children’s Mental Health Program Standards**

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

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

---

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

**School-based Day Treatment** will continue to be available in FY 2009, and the Division of Children and Youth Services will provide technical assistance to school-based day treatment sites as needed. During FY 2008, CMHCs reported a total of 312 day treatment programs, with 50 center-based programs and 262 school-based programs.
Outpatient Services, which include individual, group and family therapy, will continue to be available through the 15 CMHCs and some other nonprofit programs. In FY 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.

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

Interagency Collaboration in Provision of Foster Care Services

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

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 2009 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, permanent housing, skills training and counseling/case management to teach clients to rent or purchase housing and maintain a household, financial assistance for utilities, assistance with building and refurbishing homes, winterizing assistance, assistance with housing applications, mortgage counseling, and appliance purchase. In addition to local housing authorities, examples of other organizations assisting with housing included HOPE Credit Union, Habitat for Humanity, local MAP teams, Transitional Outreach Programs, the Salvation Army,
Mississippi

PRVO, and local faith-based organizations.

Youth with Co-occurring Disorders of Mental Illness and Intellectual/Developmental Disabilities

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

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

Mental Health Transformation Activity: Improving Access to Employment

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 freestanding 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)

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

Tobacco prevention

The Bureau of Alcohol and Drug Abuse continues to assist the Office of the Attorney General to determine the annual rate of tobacco sales to Mississippi minors. Coordinated efforts continue with completing the regulatory requirements of the Synar Amendment and the Annual Synar Report. Mississippi has always been in compliance with negotiated federal Synar rates. The Bureau of Alcohol and Drug Abuse tobacco inspections began in 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 prevention activities in all 15 community mental health centers and 13 free-standing prevention programs whose stated objectives in the Block Grant application included emphasis on tobacco prevention efforts. The revised prevention RFP guidelines for FY 2006, FY 2007 and FY 2008 require all contractors to provide some DMH/BADA approved tobacco use prevention information/education activities. Each mental health region also conducts merchant education in their respected area. Each region is required to provide education to a minimum of 40 merchants.

Substance Abuse Services for Adults and Children

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
Mississippi

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 1 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.
Mississippi

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 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.

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.
Initiatives to Prevent Out-of-State Placement

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

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

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

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

Continued development of family education/support networks and education/training activities and advocacy increase awareness across the system of care of appropriate community-based treatment alternatives to hospitalization or other long-term residential services, as well as of the need for increased support for and availability of these services. Advocacy has not only been a component of the ideal system, but also has been a part of the process of developing and implementing the system of care. Parent education/support and advocacy groups also are important in providing outreach to other parents/families and services, since these groups may be the “first contact” for information or service for some individuals. The Department of Mental Health supported for the development of an education program specifically for parents and families of children with serious emotional disturbance, the Developing Families as Allies curriculum, which was first implemented in FY 1991 in five communities by parent-professional teams; services in the community for children with serious emotional disturbance, plays a vital role in preventing and reducing the risk of hospitalization or other out of home placement of children.

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

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

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

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

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.)

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

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
Mississippi

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

Community mental health block grant funds for FY 2011 will not be expended to provide any services other than in support of comprehensive community mental health services. (Projected expenditures are described in detail under Criterion 5 in this Plan that follows.)

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

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

By March 2010, the DMH Division of Children and Youth Services staff was participating on the following interagency committees and workgroups: the Interagency Coordinating Council for Children and Youth (ICCCY), the State Level Interagency Case Review Team, the DHS Citizen Review Board, MS Alliance for Health (MASH) Conference Planning Committee, Interagency System of Care Council, Lookin’ to the Future Conference Planning Committee, Advisory Council for FASD, MS Association of Drug Court Professionals (MADCP) Drug Court Conference Committee, American Association of Pediatrics Mental Health Task Force, Underage Drinking Task Force (MAAUD), Prevent Child Abuse Advisory Council, Multicultural Task Force, Youth Suicide Prevention Advisory Council, the “Cradle to Prison
Pipeline” Summit Planning Committee (Children’s Defense Fund), and the Case Management Task Force. DMH Division of Children and Youth staff also continued to support System of Care projects and participated on the commUNITY cares Core Committee, Sustainability Committee, and, the Cultural & Linguistic Committee; and, on the MS Transitional Outreach Project Executive Council, Core Committee, and Cultural & Linguistic Committee. DMH Division of Children and Youth Services staff continued to serve on the Juvenile Justice Mental Health Task Force, the Transitional Age Task Force, and the Jackson Public Schools Safe Schools/Healthy Students Initiative. Meetings of the Mississippi State Mental Health Planning and Advisory Council were also attended by staff from the Division of Children and Youth.

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

Health and Mental Health Initiatives

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

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

Substance Abuse Initiatives

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

Note to Reader: The information in this section has been moved to Section 1

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 child-centered and family-focused activities focusing on local and state infrastructure building, technical assistance to providers and others, 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
Mississippi

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)

Note to Reader: The information in this section has been moved to Section 1

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

Note to Reader: The information in this section has been moved to Section 1

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.

Mental Health Transformation Activities: Juvenile Justice Initiatives

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. In FY 2009, the DMH continued to provide at the 50% level of funding for the SAFE Place coordinator salary. Our House Emergency Shelter reported serving 43 youth in FY 2009. The target number of children (90) was not reached as a result of the closure of the shelter March 31, 2009. Adult volunteers who are trained in crisis intervention offered assistance and transportation to the shelter for youth who could not return home. Our House Residential Program transitioned from a residential-based program to the community host homes model, which is under the therapeutic foster care umbrella of Catholic Charities, Inc. Youth being served the last weeks of the program returned to their home. 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 Catholic Charities, Inc. Host Home Program (HHP provides shelter, counseling and prevention services for runaway and homeless youth. The shelter service is provided using the Host Home model, with host homes
recruited throughout the tri-county metro area. The HHP provides 24-hour service and accessibility to youth who are eligible for services, while maintaining strict confidentiality. Youth and families receive individual and family counseling, case management and service linkage, in addition to access to transportation services. Professional staff work collaboratively with the school system to enhance academic endeavors. The HHP develops a plan for aftercare services upon admission to the program. If family reunification is not feasible then alternative permanent placements for youth are sought. The overall goal of the HHP is reunification of youth with their families or securing appropriate permanent placements to move these adolescents toward successful independence. The award year for the grant ends 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 will be merging 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.

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

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

Regionalization of Services: Availability and accessibility of services for children with serious emotional disturbance and their families in rural areas are addressed through some of the same structural and programmatic characteristics of the public community mental health system, as described under Criterion 4 in the Adult Plan. These include regionalization of community mental health services, county mental health offices and school-based services. Expansion of children’s mental health services within the existing regional system, so that components of the system of care are available statewide, is the ultimate goal of planning and service development efforts reflected in the State Plan.

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

In FY 2009, DMH Division of Children and Youth Services staff had provided certification visits and technical assistance regarding the expansion of school-based services to all 15 CMHC regions. By March 2010, DMH Division of Children and Youth Services staff provided technical assistance regarding the expansion of school-based services to CMHC regions 1, 2, 3, 5, 6, 7, 9, 10, 14, and 15.

Transportation Assistance is provided by some community mental health centers that have vehicles for transportation or through other child service agencies in some areas. For example, in FY 2008, 13 CMHCs and eight other nonprofit programs reported utilizing center-operated vans/other vehicles for children with SED; 11 CMHCs and one other nonprofit program reported making transportation available through affiliation agreement with other agencies; and, five
CMHCs and four other nonprofit programs reported utilizing local public transportation (buses, cabs, etc.).

The Telepsychiatry Project (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), with plans for expansion to some satellite sites in FY 2010. The project also is designed to provide training to front-line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing).

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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 2011)

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*Draft FY 2012–2013 STATE PLAN FOR COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SERIOUS MENTAL ILLNESS*

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

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

**Organizational Structure and Development of the System of Care**

*Note to Reader: This information moved to Section 1 of the Plan*

The majority of the public community mental health services for adults with serious mental illness in Mississippi is provided through 15 regional mental health/mental retardation commissions, which operate 15 regional community mental health centers serving all 82 counties of the state. As further discussed under Criterion #4 that follows, these centers operate regional or satellite offices/services in 81 of the 82 counties. The mental health centers are governed by regional commissions, with representative commissioners for each county in the region appointed by county Boards of Supervisors. As described in more detail in the Section I, the
Mississippi Department of Mental Health sets and monitors implementation of minimum standards for community mental health programs certified through the authority of the DMH. Implementation of these standards, which establish minimum requirements for programs in organization, management and in specific services, is monitored through on-site visits of programs throughout the year by DMH staff. Some community services (such as case management, psychosocial rehabilitation, group homes and supervised apartments and specialized programs for homeless persons who are mentally ill) are also provided to some individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These services are primarily for individuals discharged from the hospital and are in the areas in close proximity to the hospitals (Jackson and Meridian). These programs are also monitored for implementation of minimum standards applicable to the community mental health programs they provide. Community mental health centers provide pre-evaluation screening for individuals referred for evaluation for commitment to the state inpatient facilities, which provide regionalized, inpatient services. The redesign of crisis stabilization unit services is described in the section that follows on Activities to Reduce Hospitalization.

In FY 2009, House Bill 897 called for the establishment of a Joint Legislative Study Committee and allowed for formation of an advisory council to the study committee, both of which were formed and began work last year. The committee was 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 2645, passed in the 2010 legislative session, extended the Legislative Mental Health Study Committee and added the disparity of services across community mental health regions, ongoing and long-term financing, and organizational structure of the community mental health system to topics the study committee will examine.

Federal and State Resources

The FY 2011 State Plan includes objectives related to state funds appropriated for specific purposes by the State Legislature in the 2010 Session. Also included under Criterion #5 in the Children’s Plan and in the Adult Plan are objectives to request additional state funds for the 2012 fiscal year. Changes indicated under this criterion also reflect an increase to FY 2010 (current year) federal CMHS Block Grant funds. The Department of Mental Health (DMH) administers and grants to local providers funding from the federal Community Mental Health Services (CMHS) block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as PATH funding for specialized programs for homeless persons). The DMH also applies to the MS Department of Human Services for a portion of Mississippi’s federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently, administers and grants these SSBG funds to local providers. (The MS Department of Human Services is the agency in Mississippi designated to receive and allocate SSBG funds.) If SSBG funding, which totals $1.2 million for mental health services for adults and children, is no longer available in FY 2011, modifications to the plan may be required. The DMH also requests and administers through its service budget state matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers. For the past nine years of budget restrictions, the community mental health centers have also made significant contributions to matching funds provided by the Department of Mental Health for Medicaid reimbursable community mental health services provided by the centers. In FY 2011,
projections are that between $24 and $32 million will be needed for match on CMHC Medicaid payments; the higher amount will be needed if the enhanced federal share of Medicaid under ARRA is not extended until June 30, 2011.

The legislation that provides for the establishment, structure and operation of the regional commissions for mental health/mental retardation also authorizes participating counties to levy up to two mills tax for programs designed by the regional commission. The DMH also performs fiscal audits of programs receiving funding through its Bureau of Administration.

Sources listed under the heading of “Funding” within each objective in the State Plan include all potential funding for implementation or monitoring of implementation of that objective or service, including sources of funding for state office staff. The listing of sources under “Funding” does not imply that those funding sources are available to all providers of that service. Availability of some sources may be limited. In FY 2010, DMH received an increase in CMHS Block grant funds in the amount of $11,413. Of this increase, $10,870 will be utilized to support the Mississippi Coordinated Transportation Coalition and DMH’s Transformation Transfer Initiative (TTI) efforts in providing transportation to individuals with disabilities. The funds will give grants to transportation service providers to provide transportation to individuals with serious mental illness to work, recreation and other activities for community inclusion. The remainder of the increase ($543) will be spent on administrative costs.

**Ideal System Model**

*Note to Reader: The information in this section has been moved to Section 1*

The Ideal System Model for a Comprehensive Community Mental Health System for Adults with Serious Mental Illness (next page) was developed to reflect an ideal system that is responsive to the strengths and needs of all individuals with serious mental illness. At the center of the system is the person, each with his or her individual strengths and needs, which vary across time and circumstances. Revolving around the person and between the person and his or her family and components of the mental health and support system, is case management. Case management is the key to accessing and coordinating mental health and support services needed by the individual at any given time. In the ideal system, the case manager continually works with the individual to aid in identifying that person’s goals, helping them to recognize strengths and barriers, and in developing and implementing an action plan based on identified needs. The Ideal System Model for Adults emphasizes a psychosocial rehabilitation approach to making an array of appropriate mental health, social, vocational, educational, and other support options available, based on individuals' strengths, as well as their needs. Several types of service options and activities may be included in the service components of the Ideal System Model. A major change in the description of the characteristics of the system has been made to reflect a philosophy shift to one that is more person-directed and thus, individualized. Consistent with an initial 2006 Planning Council recommendation, strategies to evaluate and improve the effectiveness of local advisory councils, which include consumers and family members, have been included in system improvement efforts. The major service components of the Ideal System Model for Adults include: case management, outpatient services, crisis response services, alternative living arrangements (housing), identification and outreach, psychosocial rehabilitation services, family/consumer education and support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance abuse are also included in the system of community-based care.
Mississippi
IDEAL SYSTEM MODEL
Mississippi Comprehensive Community Mental Health System for Adults With Serious Mental Illness

CHARACTERISTICS OF THE SYSTEM
- Person - Directed
- System Access and Coordination Through Case Management
- Arrows Represent Easy Transition In, Across, and Out of Service
- Emphasis on Recovery
Other Cooperative Initiatives with the Division of Medicaid

Note to Reader: The information in this section has been moved to Section 1

The Department of Mental Health is continuing to work with the Division of Medicaid to develop a proposed State Plan Amendment and/or a waiver for submission to the Center for Medicare and Medicaid Services (CMS) that, if approved, would facilitate changes in community-based services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Bureau of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults. In February, the MS Division of Medicaid was one of 13 states that was awarded Money Follows the Person demonstration grants. MS received $37 million over the next six years. The DMH has worked closely with the Division of Medicaid to assist in this effort. We anticipate this demonstration will increase the use of home and community-based services and reduce the use of institutionally-based services. This will help to eliminate barriers that prevent or restrict flexible use of Medicaid funds and will enable individuals to receive long-term care in the setting of their choice. The state expects approximately 595 individuals will be transitioned from institutions to the community over the six-year demonstration project.

Objectives, Strategies and Performance Indicators for Adults with serious mental illness (SMI)

State Priority #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

In FY 2010, Funds were provided to continue support for operation of a 12-bed community-based residential facility for individuals with a co-occurring disorder of serious mental illness and substance abuse by the Division of Community Services at Mississippi State Hospital; continued support of these beds is projected for FY 2011.

Priority #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

**Goal:** To provide community-based residential treatment services to individuals with co-occurring disorders will continue in on site

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

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

**Description of Collecting and Measuring Changes in Performance Indicator:** The number of community residential treatment beds to be made available (12 beds)
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)

<table>
<thead>
<tr>
<th>PI Data Table A1.16</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td># Community Residential Dual Diagnosis Beds</td>
<td>12</td>
<td>12 beds</td>
<td>12 beds</td>
<td>12 beds</td>
</tr>
</tbody>
</table>

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

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

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

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

Description of Collecting and Measuring Changes in Performance Indicator: The number of individuals with co-occurring disorders to be served. (6500)

Source(s) of Information: Program grant

Special Issues: None

Significance: The need for a specialized integrated treatment program for individuals with both serious mental illness and a substance abuse problem is supported in the
professional literature and a previous study of recidivism at MS State Hospital that indicated that alcohol use is a major factor in individuals returning to the hospital.

**Funding:** State and Substance Abuse Prevention and Treatment block grant funds

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

**Population:** Adults with Serious Mental Illness

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

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

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

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

<table>
<thead>
<tr>
<th>PI Data Table A1.17</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td># Served-Dual Diagnosis</td>
<td>9295</td>
<td>6500</td>
<td>6500</td>
<td>6500</td>
</tr>
</tbody>
</table>

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

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

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

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

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

The DMH will continue to collect/report information in FY 2011-2012-2013 on the number of individuals served by the community mental health centers and Community Services Divisions
of MS State Hospital and East MS State Hospital, who have a co-occurring disorder of substance abuse and mental illness, as defined by the state. “The number (and other demographic information) of individuals receiving “integrated treatment for co-occurring disorders” is an evidence-based practice included in the CMHS Core Performance Indicators and as noted previously, efforts are continuing to monitor and provide technical assistance to facilitate implementation of guidelines for services for persons with co-occurring disorders. In FY 2010, DMH has continued work to develop the capacity to collect data on the aggregate total of individuals with co-occurring disorders served in specialized programs. Work is also continuing through its Data Infrastructure Quality Improvement Grant (DIG) project to build the capacity of providers to report the detailed demographic information in URS Table 17 on services provided for integrated treatment for co-occurring disorders.

**Mental Health Transformation Activity: Individualized Treatment/Service Planning (NFC Goal 2.1)**

**State Priority #8: Comprehensive Community-Based Mental Health Systems for Adults**

**Mental Health Transformation Activity: Involving Consumers Fully in Orienting the Mental Health System toward Recovery (NFC Goals 2.1 and 2.**

**Person-centered Planning**

The *Department of Mental Health Operational Standards Minimum Standards for Community Mental Health/Mental Retardation Services* will continue to require that providers conduct an Initial Intake Assessment for all individuals in the caseload with a serious mental illness. The assessment is conducted with every individual who has a serious mental illness within 30 days of admission referral for outpatient services and within seven days of admission for all residential treatment services. During the annual site/certification visits, it is determined if the assessments were completed during the annual site/certification visits. Staff from the DMH will review timelines on site visits to ensure assessments were conducted.

The DMH Division of Community Services is hopeful that individuals receiving services, as well as direct service and administrative staff from the community mental health regions have adopted the philosophy to provide more person-directed, recovery-oriented services for people in the system of care. The Division of Community Services will continue to review existing service standards for potential revisions that would support sustaining of PCP initiatives in the future. The Division of Community Services, NAMI-MS, the Mississippi Leadership Academy, and the Mental Health Association are also mindful of the principle of person-directed services in the training they provide to individuals receiving services and their families.

In 2009, DMH began a ten-year strategic planning effort to guide and direct the department in transformation to a community-based system that promotes recovery and resiliency. One of the main themes throughout the plan calls for the agency and services to be more person-centered and person-directed. DMH also began the revision/updating of the DMH minimum standards for
operation of community mental health programs in which DMH plans to include has incorporated the person centered/directed philosophy.

Quality Improvement System Development

The MS Department of Mental Health continues efforts to address provision of the comprehensive Mental Health Reform Act, passed by the State Legislature in 1997. Consistent with the call for increased access, quality and accountability of services in the Mental Health Reform Act, and more recently, in the agency’s Strategic Plan, the Mississippi Department of Mental Health continues work to improve its system of program evaluation and planning. In 2011, the MS State Legislature passed Senate Bill 2836. This bill named after the sister of MS author, Tennessee Williams, establishes the goal of the state mental health delivery system which is to provide services and support to citizens in the community where they live. It also requires that certain core services are provided in each county. CMHCs are required to submit an annual operational plan each year to the DMH. a key focus of which is further development of its data infrastructure and information management systems, described in more detail under Criterion 5. As noted throughout the plan, these efforts also address improving performance and outcome measurement and reporting at the local and state levels, including increasing capacity to report on National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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

Peer Review

In addition to monitoring community mental health service providers’ compliance with minimum operational standards, the Mississippi Department of Mental Health administers a peer review process involving reviewers with expertise in adult community mental health services, consumers, families and other stakeholders. Based on feedback from satisfaction surveys in FY 2008, revisions were made to improve the peer review process for FY 2009. Peer review visits FY 2009 involved a smaller, more focused team of one consumer representative, one family member and one stakeholder. During the review, a sample of each type of program is visited. The Division developed a manual/guide for Peer Reviewers that describes available services by region, and core services; thumbnail images of service locations were placed next to addresses. A pre-conference visit is also held with service providers, in addition to the exit conference at the close of the visit. In FY 2010, the Peer Review Task Force began developing a Recovery Self Assessment. The Assessment will be used to measure the community mental health centers and state hospitals transformation towards a person-driven, evidence-based, recovery-oriented system. The Assessment is tentatively scheduled to be implemented with CMHCs in FY 2011. In 2011, the peer review process was replaced with the Council on Quality Leadership Personal Outcome Measures 2005 ©. The Council On Quality and Leadership is an international not-for-profit organization dedicated to being the leader for excellence in the definition, measurement, and evaluation of personal and community quality of life for people with disabilities and people with mental illness.
Personal Outcome Measures are a tool for evaluating personal quality of life and the degree to which organizations individualize supports to facilitate outcomes. People define outcomes for themselves. Personal outcomes are important because they put listening to and learning from the person at the center of organizational life. There are 21 personal outcome measures for adults; 22 for children and young adults; and 20 for families and children under 5 years of age. As of March 2001, 37 individuals receiving services, family members and mental health professionals have been trained to conduct personal outcome interviews. As of March 2011, personal outcome interviews have been conducted at Life Help and Hinds Behavioral Health with 46 adults and/or children, young adults or families with children under 5 years of age.

**Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults**

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

**Strategy:** DMH will continue 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).

**Performance Indicator:** Improved access and outcomes of services to individuals receiving services will be reported. Number of consumers and family members involved in decision-making activities, peer review/site visits.

**Description of Collecting Changes in Performance Indicator:** DMH data

**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 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.
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 with 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 Recovery Self Assessment tools will allow the Department of Mental Health to assess how 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

Consumer Satisfaction Survey

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

<table>
<thead>
<tr>
<th>Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: To improve the outcomes of community-based mental health services.</td>
</tr>
<tr>
<td>Strategy: Continued surveying of adults with serious mental illness.</td>
</tr>
<tr>
<td>Performance Indicator: Percentage of adults with a serious mental illness who respond positively about outcomes.</td>
</tr>
<tr>
<td>Description of Collecting and Measuring Changes in Performance Indicator: 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).</td>
</tr>
<tr>
<td>Target: Maintain percentage of adults with serious mental illness who respond positively about outcomes.</td>
</tr>
<tr>
<td>Population: Adults with Serious Mental Illness</td>
</tr>
<tr>
<td>Criterion: Comprehensive, community-based mental health system</td>
</tr>
</tbody>
</table>
**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 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. The stratified random sample was increased to 20% from each community mental health region beginning with the 2009 survey 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.

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**Satisfaction Survey of Individuals Receiving Services**

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

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<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Actual)</th>
<th>FY 2012 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>% Reporting Positively about Outcomes</td>
<td>74%</td>
<td>77%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Numerator</td>
<td>1071 positive responses</td>
<td>476 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>1453 responses</td>
<td>615 responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>responses</td>
<td>responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
<td>-----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1494 responses</td>
<td>617 responses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. % Reporting Positively about Quality and Appropriateness for Adults</th>
<th>91%</th>
<th>89%</th>
<th>90%</th>
<th>89%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>1491 responses</td>
<td>616 responses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
<th>1351 positive responses</th>
<th>549 positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>1453 responses</td>
<td>615 responses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. % Reporting Positively about Outcomes</th>
<th>74%</th>
<th>77%</th>
<th>72.5%</th>
<th>71%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>1071 positive responses</td>
<td>476 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>1451 responses</td>
<td>608 responses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. % Reporting on Participation in Treatment Planning</th>
<th>80%</th>
<th>76%</th>
<th>77%</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>1158 positive responses</td>
<td>461 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>1451 responses</td>
<td>608 responses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. % Reporting Positively about General Satisfaction with Services</th>
<th>91%</th>
<th>89%</th>
<th>91%</th>
<th>89%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>1366 positive responses</td>
<td>549 positive responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>1493 responses</td>
<td>615 responses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note to Reader: The following section is deleted here, but is addressed in the section that combines objectives that pertain to both children’s and adults’ services.*
Mental Health Transformation Activity: Implementation of Consumer Information and Grievance Reporting System (NFC Goal 2.5):

The Office of Constituency Services was established by the Department of Mental Health in response to a provision in the Mental Health Reform Act. The major responsibilities of this office include establishing and maintaining a 24 hour toll-free help line for responding to needs for information by consumers and their family members and other callers to the help line. This office is also responsible for responding and attempting to resolve consumer complaints about services operated and/or certified by the Department of Mental Health. Policies and procedures have been developed for resolving consumer complaints, both formally and informally. This office also maintains a computerized database of all DMH certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. Information is accessible to all callers through staff via a toll-free telephone number. The number is accessible 24 hours a day, seven days a week. OCS is also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals according to established policies and procedures. Through mid-FY 2010, OCS has received 6497 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran.

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

OCS staff participates in certification visits to each program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. This Office also continues to process and attempt to resolve consumer complaints through formal and informal procedures and track calls to develop reports for DMH management staff. Reports about the nature and frequency of calls to the help line (deleting all confidential information) are distributed quarterly to the DMH Executive Director, Bureau Directors and the OCS Advisory Council. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS has developed training modules on serious incident reporting, handling crisis and suicide calls, and any applicable minimum standards monitored by OCS. These modules are available as requested by any DMH-certified program.

In FY 2010, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities). Additionally, OCS continues to publish, distribute, and update the “Directory on Disk” program to all DMH facilities and community mental health centers, as well as DMH Central Office staff. This directory gives service providers access to basic program/service information for over 2700 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the
statewide database used for information and referral (approximately 45 new programs were added and over 344 individual programs’ information has been updated in FY–2010); this process is also ongoing.

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

**Population:** Adults with serious mental illness

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

**Brief Name:** Constituency Services Call Reports

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

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

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

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

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

**Funding:** State General Funds

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**Mental Health Services**

**Local Community Support Systems Planning**

In 1993, a task force on community support developed requirements for each service of the ideal system of care that could be used as an outline for service providers to use to plan their local plans, referred to at that time as Community Support Programs (CSP). Since then, this outline, which has been modified somewhat over time, has been used for the required program
narrative outline required when service providers apply for CMHS block grant funds. These grants make available a portion of the CMHS Block Grant to community mental health centers to be used on a purchase-of-service basis for various services within the system of care.

Regional community mental health centers are required in their plans to describe how these services and other community support services for adults with serious mental illness will be provided at the local level, addressing the following components: outpatient services; family and consumer support; access to inpatient services; availability of alternative living arrangement services; protection and advocacy; programs for psychosocial and vocational rehabilitation; crisis response system; case management; outreach; and, access to medical/dental services and to other support services, such as transportation and social activities.

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

Note to Reader: The following section is deleted here, but is addressed in the section that combines objectives that pertain to both children’s and adults’ services.

Multicultural Task Force

Mississippi has a significant minority population. According to 2000 U. S. Census figures, Mississippi has a population of 2,844,658, with an estimated 39% of its citizens identified as nonwhite. Of the total number of nonwhite individuals, approximately 94% are African-American. Additionally, as a largely rural state, there is a great need for cross-cultural awareness and sensitivity in outreach and mental health service delivery activities.

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the task force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. The task force membership was expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling was also helpful. There were 36 members on the task force during the development of the Cultural Competency Plan including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-Mississippi; Mental Health Association Director, Jackson State University, School of Social Work; Jackson State University, SMHART (Southern Institute for Mental Health Advocacy, Research and Training); Jackson Hinds Community Health Center, Ellisville State School, Jackson Healthcare Center, Grant Consultant; and Chairperson of the Mississippi State Mental Health Planning and Advisory Council. Currently, there are 17 active members on the task force. The Multicultural Task Force Strategic Map mission statement is: “to promote an
effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures.” The definition of cultural competency chosen by the task force members is: “the acceptance, understanding and embracing of all cultures.” “Culture” refers to an integrated pattern of human behaviors that includes language, thoughts, communications, actions, customs, beliefs, values and institutions of all individuals. Task force has developed the Draft, Mississippi Department of Mental Health Proposed Plan for Cultural Competency, and a subcommittee met to develop the Communication Continuum for Sharing the Cultural Competency State Plan. By mid-year in FY 2010, the Multicultural Task Force had met twice (in November, 2009 and April, 2010). The task force organized the statewide Day of Diversity that was held on October 13, 2009. An annual report of the task force’s activities was presented to the Planning Council on April 22, 2010.

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 2011 (at least four), with at least an annual report to the Mississippi State Mental Health Planning and Advisory Council, and the number of new members from other ethnic groups added to the Task Force.

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

Special Issues: None

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

Funding: State funds

Objective: To develop a committee to guide the implementation of the Cultural Competency Plan to ensure that culturally competent services are provided to individual receiving services.
Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

Brief Name: Implementation Cultural Competency Workgroup

Indicator: Meeting/activity by the Cultural Competency Workgroup

Measure: The development of the committee and number of meetings

Source(s) of Information: Minutes of the workgroup meetings

Special Issues: None

Significance: The function of the workgroup is to guide the implementation of the Cultural Competency Plan.

Funding: State Funds

Local Provider Cultural Competence Assessment

In FY 2001, the Multicultural Task Force initiated planning for use of a cultural competence assessment instrument at the local level, with introductory information being provided to CMHCs regarding the potential piloting of such an assessment. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. Since 2002, a cultural competence assessment recommended by the task force has been implemented by community mental health regions 1, 2, 3, 4, 6, 7, 8, 11, 14 and 15. Weems Mental Health Center has agreed to participate in the cultural competency assessment project. Following these assessments, DMH staff has continued to offer and/or provide follow-up consultation to local providers in developing recommendations for action steps based on assessment results. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff have will continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results. By August 2010, Region 2 completed the local cultural competency assessment; results will be discussed with the regional center staff by September 30, 2010.

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health system

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

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

**Source(s) of Information:** Division of Community Services Activity Report

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

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

**Funding:** State and local funds

As of April 2010, an NCBI training session had been conducted for Mississippi Families As Allies for Children’s Mental Health, Inc. (April 23, 2010), which was attended by approximately 60 participants.

**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 service providers (Minimum of 3)

<table>
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<tr>
<th>PI-Data-Table-A1.4</th>
<th>FY-2009 Actual</th>
<th>FY-2010 Actual</th>
<th>FY-2011 Target</th>
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<tbody>
<tr>
<td># of NCBI Training Sessions for service providers</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>3</td>
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</tbody>
</table>

**Source(s) of Information:** NCBI: MS Chapter Training Records
Mississippi

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

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

Funding: State and/or federal funds

Outpatient Services, a component of the ideal system, includes diagnostic and treatment services in various treatment modalities for those persons requiring less intensive care than provided by inpatient services, including individuals with serious mental illness. Outpatient services include: individual, group, family, and multi-family group therapy and aftercare services, which are currently provided by all 15 CMHCs; medication evaluation and monitoring; emergency services and inpatient referral, part of the crisis response component of the ideal system, provided through the 15 regional CMHCs; family education/support and consumer education/support services, case management services, available to adults with serious mental illness and the Community Services Divisions of East MS State Hospital and MS State Hospital; pre-evaluation screening and civil commitment services and psychosocial rehabilitative services, which include clubhouse programs.

Mental Health Transformation Activities: Improving Consumer Access to Employment Services and Supports

Rehabilitation, Employment and Educational Services

Psychosocial rehabilitative services are therapeutic activity programs provided in the context of a therapeutic milieu in which consumers can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial rehabilitative services, which involve a continuum of services based on the level of need of the consumer, include psychosocial rehabilitation (clubhouse), day support, and acute partial hospitalization services, as well as psychosocial rehabilitation specialized for elderly persons.

Psychosocial Rehabilitation is a community support service for individuals with serious mental illness, which consists of a network of services that help them assist individuals develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse refers to a program of structured activities designed to support and enhance the role-functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental support.
All CMHCs in the state provide psychosocial rehabilitation programs based on the clubhouse model. Principles of the clubhouse programs are:

1) to provide programs that enhance individuals’ skill development;
2) to improve employment opportunities for persons with psychiatric disabilities;
3) to improve the capabilities and competence of persons with psychiatric disabilities…potential is emphasized over alleviating symptoms;
4) to provide individuals the opportunity for active participation in their rehabilitation within an atmosphere in which things are done with the consumer and not to them;
5) to promote positive expectations and respect for individuals, which are the essential ingredients of the program.

Availability and Improvement of Psychosocial Rehabilitation Programs

As of April 2010 there were 60 clubhouse sites operational statewide. There are four ICCD certified clubhouses in Mississippi: Regions 5 (Greenville), Region 6 (Greenwood), Region 12 (Hattiesburg), and Region 9 (Jackson). Region 5 has been officially defined by ICCD as a Welcome Center. The ICCD Clubhouse in Greenville continues to provide a one week training program, which includes transitional employment to clubhouses in Mississippi. The DMH also continued to support Region 5 in maintaining a clubhouse thrift store in the community. 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 to 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. The number of programs traveling to attending the training site has declined in past year primarily due to budget constraints. In FY 2010, the Director of the ICCD-certified clubhouse in Greenville provided technical assistance about ICCD certification to 13 individuals from Region 7, Community Counseling Services. Region 6 (LifeHelp) has submitted an application for ICCD certification for clubhouses located in Lexington and Indianola. The Opportunity Clubhouse, operated by the Division of Community Services at Mississippi State Hospital, is conducting a self study for the ICCD certification. By mid–FY 2010, one representative from Region 12 (Pine Belt Mental Healthcare Resources) was scheduled to attend ICCD training in June 2010, and a group of individuals from Region 6 (LifeHelp) was scheduled to attend the training in July.

Note: The rehabilitation services and related activities addressed by the following goal will continue to be available, and the number of individuals receiving psychosocial rehabilitative services tracked; however, since some of these objectives represent maintenance activities, the specific goals/objectives are being deleted as part of edits to make the plan more succinct.

Goal: To provide rehabilitation services for adults with serious mental illness.

Drop-In Center
In 2010, the Mississippi Department of Mental Health continued to provide funding support to drop-in centers in Gulfport and in Corinth. By mid-FY 2010, the center in Gulfport had served 62 adults with serious mental illness, and the center in Corinth provided services to 30 adults with serious mental illness. DMH will not provide funding for the drop-in center in Corinth in FY 2011.

**Priority Area#8: Comprehensive Community-Based Mental Health Systems for Adults**

**Goal:** To make available funding to support one drop-in center for adults with serious mental illness.

**Strategy:** Availability of funding through DMH to help support one drop-in center.

**Performance Indicator:** The number of individuals served by the drop-in center will be tracked.

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

**Objective:** To make available funding to support one drop-in center 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 one drop-in center.

**Measure:** The number of individuals served by the drop-in center will be tracked.

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

**Special Issue(s):** None

**Significance:** The drop-in center, in addition to providing services to individuals with serious mental illness in the Gulf Coast area, will also provide technical assistance to programs with existing or new drop-in centers.

**Funding:** Federal and state.
Additionally, The day program for individuals at CMRC is based on a psychosocial model and focuses on transitioning individuals to a more independent setting in the community.

Clubhouse Coalition

The Clubhouse Coalition was established in 2002 to evaluate and recommend appropriate changes within the current clubhouse model of psychosocial rehabilitative services. The primary objective of a Clubhouse Coalition is to form alliances and to collaborate with other organizations and state agencies that work to improve services for individuals with mental illness (such as the Department of Rehabilitation Services, the National Alliance on Mental Illness and the Mental Health Association). The coalition includes clubhouse coordinators from the 15 mental health regions and two members from each clubhouse. The Clubhouse Coalition meets twice a year.

During the first part of FY 2009, there was transition in staff support for the Clubhouse Coalition, related to the establishment of the Division of Consumer and Family Affairs and the concurrent need for staff to support planning and development of a statewide Consumer Coalition and the statewide Mental Health Community Conference, attended primarily by consumers. In the later part of FY 2009 and continuing into FY 2010, the Division of Community Services will resume support of the Clubhouse Coalition, which will include clubhouse coordinators from the 15 mental health regions and will address issues specific to performance of clubhouse programs. Given budget constraints on travel and availability of staff time for support, the minimum number of times the Clubhouse Coalition is projected to meet in FY 2009 was reduced from four to two.

Training in the Clubhouse Model

By mid-2010, one representative from Region 12 (Pine Belt Mental Healthcare Resources) was scheduled to attend ICCD training in June 2010, and a group of individuals from Region 6 (LifeHelp) was scheduled to attend the training in July.

National Outcome Measure: Evidence-Based Practice – Supported Employment (URS Developmental Table 16)

As in previous years, the DMH will continue to collect/report information on the number of individuals served in transitional employment programs, as defined by the state. DMH has continued work in FY 2010 to develop capacity to collect data for evidence-based practices. The federal definition of “supported employment” as an evidenced based practice as proposed in URS Developmental Table 16 has some components that are similar to the state definition of supported employment, but differs along some components. DMH will continue activities through its Data Infrastructure Grant (DIG) project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported employment. DMH is continuing work on development of capacity for collection of data for the National Outcome Measures on evidence-based practices with support from the CMHS Data Infrastructure (DIG) Quality Improvement grant.
National Outcome Measure: Increased/Retained Employment (URS Table 4); Individuals employed as a percent of those served in the community.

### Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

**Goal:** Facilitate the employment of individuals with serious mental illness served by the public community mental health system.

**Strategy:** Number of persons served by the public community mental health system who are employed.

**Performance Indicator:** 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.

**Description of Collecting and Measuring Changes in Performance Indicator:** Aggregate reports from DMH funded/certified providers in Uniform Reporting System (URS) Table 4: Profile of Adult Clients by Employment Status

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**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 was 10.4%, compared to 7.7% at approximately the same time last
Mississippi

year (March, 2009) and compared to the national average unemployment rate for April 2010 of 9.7%). 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 4. DMH plans to pursue collection of data in the Optional table 4A in FY 2011 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.

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<td>Fiscal Year</td>
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<td>FY 2011 Target</td>
<td>FY 2012 Target</td>
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<td>Performance Indicator</td>
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<tr>
<td>Individuals employed as a percent of those served in the community</td>
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<td>17.7%</td>
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<td>Numerator: # of persons employed-competitively, full- or part-time (includes supported employment)</td>
<td>9,437*</td>
<td>9286</td>
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<tr>
<td>Denominator: # of persons</td>
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Day Support is a psychosocial rehabilitative service that became available in FY 2002 for adults with serious mental illness. Day support, which is the least intensive psychosocial rehabilitative service, is a program of structured activities designed to support and enhance the role functioning of consumers who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Day support is the least intensive psychosocial rehabilitative service. Structured activities of the program are designed to maintain individuals in an environment less restrictive than inpatient or therapeutic residential treatment; develop daily living, social and other therapeutic skills; promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills; provide assistance in maintaining and learning new skills that promote independence; develop interpersonal relationships that are safe and wanted by the individual to eliminate social isolation; and, to improve physical and emotional well being. Day support programs include, at a minimum, social skills training, group therapy, individual therapy, training in the use of leisure time activities, and coping skills training. The program must provide individuals with opportunities for varied activities, active and passive, and for individuals to make choices about the activities in which they participate.

Acute Partial Hospitalization is a psychosocial rehabilitative service that is designed to provide an alternative to inpatient hospitalization or to serve as a bridge from inpatient to outpatient treatment. Program content can vary, depending on individual strengths and needs, but must include close observation/supervision and intensive support, with a focus on the reduction and/or elimination of acute symptoms. Acute partial hospitalization provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired.

Other Vocational Rehabilitation/Employment Services
Note to Reader: This information is being updated and will be moved to Section I of the Plan.

DMH minimum standards require that transitional employment programs be available as part of clubhouse programs, which are available in all 15 CMHC regions. In addition to transitional employment programs offered by the CMHCs, individuals with serious mental illness have access to other VR services through referral(s) with VR service entities.

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

The Department of Mental Health plans to continue increased collaboration with MS Department of Rehabilitation Services staff to explore options for expanding supported and competitive employment options for individuals with serious mental illness that might be available through that agency. A representative of the Mississippi Department of Rehabilitation Services, Office of Vocational Rehabilitation, has continued to participate on the Transitional Age Services Task Force and provided members with information on meeting the employment needs of youth/young adults in the transitional age range (14 to 25 years). The Office of Vocational Rehabilitation also participates on the Transportation Coalition. The DMH Division of Community Services has a representative on the board of APSE, Mississippi Advancing Employment Connecting People, MS APSE, which held its second conference, Opening Doors to Employment...Making It Happen.

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

For the past ten years, the Mississippi Partners for Informed Choice (M-PIC) program has provided Work Incentives Planning and Assistance (WIPA) services to individuals receiving...
Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability. Work incentives planning and assistance services are provided free to these recipients through the program in order to enhance their ability to make informed choices regarding reentry into the workforce or entry into the workforce for the first time. M-PIC has Community Work Incentives Coordinators (CWICs) working in designated regions of the state who are available to comprehensively demonstrate the effect of wages on the SSDI/SSI recipient’s disability benefits to dispel any unjustified fears of benefit loss due to work. The CWICs will work closely with the Social Security Administration, the Mississippi Department of Rehabilitation Services, other federal and state agencies and community service agencies, as needed, in order to maximize work incentives. Services under WIPA are designed to: analyze the impact of work and earnings on disability benefits; enhance individuals’ ability to make informed choices in transitioning from benefits to work; identify work incentives to help achieve work goals; advise on how and when to use the Ticket to Work; assist in developing a plan for employment; coordinate with other agencies regarding a plan for employment; and, refer to other agencies that may provide additional supports to better enable the transition to work.

Given the potential benefit of services provided by the Mississippi Partners for Informed Choice to individuals with serious mental illness who are SSI and/or SSDI recipients, as well as the impact of the Ticket to Work Program changes, staff from the Mississippi Department of Mental Health and the Department of Rehabilitation Services, Division of Selected Social Security Services have partnered to provide a series of educational presentations on these rehabilitation services topics. MDRS staff will continue to make available information through presentations and exhibits for mental health staff and consumers. For their service areas, M-PIC staff provided training and educational information to local mental health center staff and individuals with mental illness throughout the state. DMH staff has facilitated linkage with MDRS staff to increase collaboration of local providers and consumer education programs as part of the agencies’ outreach efforts. MDRS’s Division of Selected Social Security Services staff look forward to continuing their partnership with the DMH to provide support services to individuals with mental illness.

**Educational Services** may also be accessed by community mental health centers for some adults with serious mental illness. These services generally include GED and adult literacy, and/or vocational training programs provided through community colleges, local schools, and/or volunteer organizations. Examples of Specific Vocational/Employment/Educational Services are 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 2009 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, literacy training programs, adult education programs, academic and vocational education, money management/budgeting training, nutrition education, parenting education, computer education, literacy programs, educational programs related to illness self-management, adult basic education, financial assistance for education, single parent/displaced homemaker services, community college coursework, education about safety issues and public transportation, independent living skills training, education about health living/nutrition, education about communicable diseases, leadership/advocacy skills training, functional living skills and income tax preparation.
The CMHCs, CMRC and the Community Services Divisions of the two larger state hospitals continued linkages with a variety of agencies in local communities that made these services available. Examples of individual agencies providing these types of support services in 2009 included: the MS Department of Rehabilitation Services, WIN Job Service, Alliance, MS Highway Safety Patrol, Mississippi Cooperative Extension Services, CARES of Mississippi, private staffing companies, Mississippi State Employment Security Commission, Goodwill Industries, the Salvation Army, Gaining Experience to Succeed (volunteer programs), Piggly Wiggly food stores, community colleges across the state, Job Corps, local literacy councils/programs, family and community resource centers, local public library, NAMI-MS, MS Department of Human Services, Boys and Girls clubs, area churches/faith-based organizations, universities, public school districts, county human resource offices, Recruitment and Training Program of Mississippi, county extension local vocational technical centers, the United Way, Mental Health Association of the Capital Area, Inc., Disability Rights Mississippi, Inc., the City of Jackson, Mississippi Community Education Center, Institute of Disability Studies (University of Southern Mississippi) and the Mississippi Leadership Academy.

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

The need for additional adequate and affordable housing for individuals with serious mental illness is a major issue challenging the system in Mississippi and most importantly, individuals’ opportunities for full recovery. The availability of safe, affordable housing, as mentioned, is key to the success of system transformation efforts focused on diverting individuals from hospitalization or re-hospitalization and on diverting individuals from the criminal justice system. The Department of Mental Health’s Ten Year Strategic Plan included an objective to establish a Housing Task Force in Year 1. In FY 2010, the Division of Planning in the Bureau of Community Services, which had also been also participates in the National Association of State Mental Health Program Directors (NASMHPD) Housing Task Force, continues to began work with the task force, to network with potential partners at the state and local level, and to seek specialized technical assistance to facilitate development of action steps for a strategic plan for housing for individuals with serious mental illness. The task force has held two meetings in FY-2010 (December 2009 and March 2010). The Mississippi Development Authority (MDA)’s representative on the Mississippi State Mental Health Planning and Advisory Council, who is a key staff person in development of the state’s Five-Year Consolidated Plan for use of federal housing funds, has been very supportive of initial activities, as have other members of the Council, its Long Range Planning Committee and the Housing Task Force. Other important Partners who have agreed to work on the housing planning initiative include: the Mississippi Home Corporation, the University of Southern Mississippi, Institute of Disabilities Studies (IDS), USDA, Office of Rural Development, and individuals who serve on the three continua of care entities in the state; efforts to expand partnerships at the state and local levels are ongoing. On the recommendation of Council members who attended the SAMHSA-sponsored Olmstead Conference in the fall of 2009, DMH applied for technical assistance that was available from the Center for Mental Health Services (CMHS) to support states in their transformation efforts to achieve full community integration of adults with serious mental illnesses and children with serious emotional disturbance. The Bazelon Center for Mental Health Law, in collaboration
Mississippi

with Magna Systems, the technical assistance subcontractor for this federal initiative, worked with state staff to address DMH’s request for technical assistance on supportive housing, which resulted in a one-day on-site visit by the Technical Assistance Collaborative (TAC) in January 2010. Staff from TAC met with members of the Housing Task Force and some additional DMH and community mental health program staff to provide an overview of the best practice model of Permanent Supportive Housing (PSH) model; descriptions of models for service linkage with PSH units; examples of PSH in other states/local areas; overview of statistics on need and emerging trends/policy/funding changes currently under review/discussion at the national level; and, a question/answer group session. TAC staff also met with DMH staff to address specific operational questions, given current system challenges and changes, and to provide assistance in thinking about strategies and “next steps.”

The MS DMH applied for and received Transformation Transfer Initiative (TTI) funding from the Center for Mental Health Services, Substance Abuse Mental Health Services Administration; housing was one of three transformation areas addressed in the application. The TTI is funding assistance from two consulting entities with expertise in planning housing and housing-related services (Simons Consulting, LLC and the Technical Assistance Collaborative, Inc.) to support the DMH staff and the Housing Task Force in development of a statewide strategic plan for housing for individuals served by the public mental health system. This strategic planning initiative, which is underway and projected to continue into FY 2011, will addressed the following major goals: (1) needs assessment to research current housing stock by location and level of support; (2) gap analysis to identify priority system issues, refine strategies for development of housing and housing-related supports and to address consumer and family input on need and preferences; (3) building housing partnerships at the state and local levels, including facilitating work to identify relevant policy, regulatory or process issues and to develop collaborative strategies to address those issues; (4) assessment and planning of service system models, reimbursement mechanisms and capacity to contribute to housing and service system re-design models; and, (5) development of additional funding mechanisms, focusing on maximizing mainstream housing affordability opportunities, on designing a bridge subsidy program and readiness for use of potential new federal housing resources.

Community Living Services

In an effort to consolidate and refine the Mississippi Department of Mental Health Minimum Operational Standards for Community Mental Health/IDD Services, DMH examined standards for services provided to different populations that could be combined where they were addressed separately in the past; therefore, the standards for community living across target populations were examined and it is projected that draft revisions will address overlap in services standards and/or definitions across groups.

The DMH offers grants to community mental health centers, private providers, and the Community Services Divisions of two of its state hospitals to help support array of community-based housing options for persons with serious mental illness. These housing options currently include:

**Group homes** for adults with serious mental illness are homes shared by individuals in a community setting with 24-hour supervision. The program is designed to help individuals
achieve more independence in a community living situation. As of mid-FY 2010, the Department of Mental Health had certified 26 group homes for adults with serious mental illness, with a total capacity of 325 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 MS State Hospital, Division of Community Services, 77 beds; Mississippi State Hospital, Division of Community Services, 27 beds; and, Central MS Residential Center, 48 beds.

Transitional Residential Treatment Services or Halfway Houses for adults with serious mental illness provide a comprehensive residential treatment program to persons with serious mental illness and are specifically designed to serve individuals who are at high risk of hospitalization. Emphasis is placed on achieving stabilization, on developing and refining social and basic living skills, and acquiring other coping skills. In FY 2010, DMH had certified three residential transitional programs in the state with a total of 34 beds, two of which are in the regions near the two larger state psychiatric hospitals (EMSH Community Services operated 10 beds (Enterprise), and MSH Community Services operated eight beds in Jackson), with the third in Greenwood (16 beds).

Supervised housing is currently defined as a form of housing service that provides a residence for three or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a group home. Supervised housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day, consumers may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities. The persons living in the supervised housing service must be registered consumers of the provider program who have been determined to have a serious mental illness. As of March 2010, DMH had certified 14 supervised housing programs in six CMHC regions: Region 5 (capacity 30), Region 6 (capacity 44), Region 7 (capacity 51), Region 8 (capacity 8), Region 14 (capacity 12) and Region 15 (capacity 8); MSH Community Services had a capacity of 8 supervised housing beds.

Supported living is currently defined as programs designed to provide individuals some assistance while allowing them to maintain an independent residential arrangement. Supported living programs differ from “supervised apartments” in that supported living programs may have little or no involvement from the center in operation of the residence, support staff may not live in close proximity to the residence and contacts with consumers occur on a weekly or less frequent basis.
Other Housing Options  Community mental health service providers also continued-efforts at the local level to access and/or expand community housing options for individuals with serious mental illness. Region 4 CMHC has been involved with four HUD-funded apartment projects, located in Corinth, Iuka, Ripley and Booneville, with a total of 18 apartments per site. Region 15 has been involved in a 17-unit project in Vicksburg. In Region 6, 14 HUD apartments serve 16 individuals (two of the apartments are two-bedroom units); NAMI-MS is collaborating on a HUD project planned for Lexington, which is also in Region 6.

Strategic Planning for Housing Initiative

The Mississippi Department of Mental Health’s (DMH) Ten-Year Strategic Plan included an objective to establish a Housing Task Force to address the need for access to adequate and affordable housing for individuals served by the agency. In the fall of 2009, the Division of Planning in the Bureau of Community Services began work to establish the task force, to identify and network with potential partners at the state and local level, and to seek specialized technical assistance to facilitate development of a strategic plan for housing for individuals with disabilities served by the agency (who include individuals with mental illness, with intellectual/developmental disabilities, and/or with substance abuse problems). Transformation Transfer Initiative (TTI) funding from SAMHSA enabled the DMH to receive much-needed specialized technical assistance in FY 2010 and FY 2011 from consulting entities with expertise in planning housing and housing-related support services to facilitate a strategic planning process for housing. From this technical assistance, operational issues that will impact the design and implementation of the DMH strategic housing plan development, priority system issues and recommendations for advancing the initiative were identified. A major focus and accomplishment of the initiative was outreach and development of working relationships with representatives from housing finance and assistance agencies/organizations (e.g., HUD Hub Office of Public Housing, MS Home Corporation, USDA/Office of Rural Services, MS Development Authority, and USM/IDS staff); these relationships are central to implementing a comprehensive approach to developing more housing options for persons with serious mental illness or co-occurring disorders on a statewide basis. The HUD Hub (state) Office of Public Housing has agreed to work with the DMH to develop a Memorandum of Understanding to identify integration strategies, public housing authority (PHA) partnership opportunities and to increase awareness of services for both housing and support service entities. The specific strategy will address: education of PHAs on state services and education of service providers on housing programs, availability and processes; identification of barriers for people with disabilities to obtain housing; collaboration through the statewide housing planning process; promotion of disability preferences with housing authorities; and, targeting of new development of housing stock targeted for people with disabilities. Mississippi Home Corporation, which administers the tax credit program in the state, has continued to be supportive and actively involved in the DMH’s planning process. In the fall of 2010, DMH staff participated in a public meeting held by the Mississippi Home Corporation about proposed changes to the FY 2011 Qualified Allocation Plan for the Tax Credit Program, provided an overview of the strategic planning initiative, expressed support for provisions in the Qualified Allocation Plan (QAP) for the tax credit program so that projects that include meeting the needs of special populations are fundable and encourage the development of additional safe and affordable housing options for people with disabilities. In February, 2011, DMH Planning staff and one of the consultants presented the housing
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planning goals and objectives at the 2011 Annual Housing Affordability Conference, held by the Mississippi Home Corporation and attended by developers, public housing authority staff, property managers and other entities concerned with housing. They were joined by an executive director of a community mental health center, the director of a regional crisis stabilization unit and the Director of the HUD Hub Office of Public Housing in a well-attended roundtable discussion with conference participants following the housing initiative overview presentation. In June, DMH staff provided an overview of the strategic housing planning initiative at the Occupancy Workshop, hosted by the Mississippi Association of Housing and Redevelopment Officials (MAHRO) and HUD. Staff from a regional community mental health center and DMH staff are also scheduled to present at the Housing Summit, hosted by HUD in August.

Existing relationships were expanded through the initiative to address housing issues more specifically. For example, a memorandum of understanding between the DMH and the MS State Department of Health was developed to improve communication and coordination of care for individuals living in homes that fall under the regulatory purview of the agencies, and to facilitate effective and efficient oversight of these homes; DMH staff and other members of the DMH Housing Task Force are involved in the Advisory Committee for the recently approved Money Follows the Person project, funded by the Centers for Medicare and Medicaid Services (CMS) and administered by the Mississippi Division of Medicaid; and, active networking with the University of Southern Mississippi’s Institute of Disabilities Studies, which implements a housing counseling and assistance program, has increased. Additionally, to obtain perspectives of consumers with disabilities on an ongoing basis, questions about housing satisfaction and preferences are being addressed in conjunction with Personal Outcome Interviews that are being initiated in the revised peer review process (administered by the DMH, working with the Arc of Mississippi).

In FY 2010, the DMH was approved for the SAMHSA-supported SSI/SSDI Outreach, Access and Recovery (SOAR) Technical Assistance Initiative, which will be administered through the Projects for Assistance in Transition from Homelessness (PATH) program in the Department of Mental Health and will contribute to the success of the strategic planning initiative for housing. (See also Criterion 4.)

Other planning activities in the initiative involved: exploring the potential for increasing access to existing mainstream affordable housing and housing assistance services and for developing additional housing options that might be addressed in the strategic plan; assessment of current and potential community services system components to support individuals in permanent supportive housing; collection of information on development of a bridge subsidy program; and, identification of key issues/strategies that need to be included in the plan to address service linkage necessary for timely coordination of housing with support services.

National Outcome Measure: Evidence-Based Practice – Supported Housing (URS Developmental Table 16)

DMH continues work in FY 2010 to develop capacity to collect data for evidence-based practices by the FY 2011 timeline. The federal definition of “supported housing” as an evidenced
based practice as proposed in URS Developmental Table 16 is similar to what is referred to in Mississippi as “supervised living.” DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project to examine the similarities and differences in state and proposed service definitions, including the issue of data collection for supported housing. DMH is continuing work on developing capacity for collection of information, for reporting evidence-based practices (such as supported housing) and for improving data integrity for the National Outcome Measures, with support from the CMHS Data Infrastructure Grant (DIG) for Quality Improvement.

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

<table>
<thead>
<tr>
<th>Priority #8: Comprehensive Community-Based Mental Health Systems for Adults</th>
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<tbody>
<tr>
<td><strong>Goal:</strong> 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.</td>
</tr>
<tr>
<td><strong>Strategy:</strong> Number of adults served in the public community mental health system, reported as homeless/in shelters</td>
</tr>
<tr>
<td><strong>Performance Indicator:</strong> Number of adults reported in homeless/in shelters as a percentage of adults served in the public community mental health system</td>
</tr>
<tr>
<td><strong>Description of Collection and Measuring Changes in Performance Indicator:</strong> 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</td>
</tr>
</tbody>
</table>

**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
According to Uniform Reporting System Guidelines for Table 15 (Living Situation), the number of adults who are homeless/in shelters within all DMH-certified and funded community mental health programs are reported, including specialized programs funded through the federal Projects for Assistance in Transition from Homelessness (PATH) program. Therefore, the percentage of adults who are reported as homeless/in shelters is not projected to increase or decrease substantially, unless significant changes in the numbers of adults served by these specialized programs occur. DMH is continuing work in FY 2009 to develop capacity to collect data through a central data repository (CDR) for the Uniform Reporting System (URS) tables, including URS Table 15. As noted under the objective on Information Management Systems Development under Criterion #5, the CDR is now in place and the DMH continues to use its Mental Health Data Infrastructure grant project funds to support work with providers to increase the number that submit data to the CDR that passes edits. Work on ensuring standardization of definitions to be consistent with federal definitions also will continue. DMH will continue activities through its Data Infrastructure Grant (DIG) Quality Improvement project 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.

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<tbody>
<tr>
<td>FY 2009</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Actual</td>
<td>FY 2012 Target</td>
<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>% of adults reported homeless/in</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Mississippi

<table>
<thead>
<tr>
<th>shelters</th>
<th>.8%</th>
<th>.78%</th>
<th>.8%</th>
<th>.7%</th>
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</thead>
<tbody>
<tr>
<td>Numerator: # adults reported homeless/in shelters by DMH certified/funded providers</td>
<td>560</td>
<td>474</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>Denominator: # adults reported with living situations by DMH certified/funded providers, excluding persons with living situation Not Available</td>
<td>59,625</td>
<td>61,028</td>
<td>?</td>
<td>59,000</td>
</tr>
</tbody>
</table>

The following sections on substance abuse services are under review for needed additional updates.

Substance Abuse Services

As indicated in the Children’s Services Plan, substance abuse services are also administered by the MS Department of Mental Health, Bureau of Alcohol and Drug Abuse (BADA). Community mental health centers are the primary providers of both community mental health and outpatient substance abuse treatment for adults. Specific objectives addressing the needs of individuals with co-occurring disorders of mental illness and substance abuse are described in the following section under this Criterion on Activities to Reduce Hospitalization/Rehospitalization, since alcohol use has been found to be a major factor in individuals returning to the hospital. The existing substance abuse treatment system components administered by the Bureau of Alcohol and Drug Abuse that address the needs of adults are described below:

Substance Abuse Services for Adults and Children

Substance Abuse services are administered by the MS Department of Mental Health through the Bureau of Alcohol and Drug Abuse. Community mental health centers, free-standing programs and two state-operated psychiatric hospitals are the primary providers of substance abuse treatment.
General Outpatient Services: The DMH Bureau of Alcohol and Drug Abuse continues to make funding available for general outpatient substance abuse programs located across the 15 community mental health centers. BADA also continues to certify 9 free-standing programs which also provide these services. One of the free-standing programs, Metro Counseling Center provides day treatment services for women at the Rankin County Correctional Facility. These services provide the individual the opportunity to continue to keep their job or if a student, continue to go to school without interruption. Their condition or circumstances do not require a more intensive level of care. At the conclusion of FY 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 continues to make available funding to 4 certified programs and 1 adolescent program which is the Bradley Sanders Complex, an extension of East MS State Hospital. At the close of FY 2009, there were 1,214 individuals who received these services.

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

Transitional Residential Services: These services provide a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. An individual must have completed a primary program before being eligible for admission to a transitional residential program. These services are provided by 9 community mental health centers and 13 certified free standing programs. In FY 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 approximately 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 were eligible for the residential alcohol and drug abuse treatment program at the state penitentiary.

**Private Resources (To be updated)**

The Department of Health, which collects data on private chemical dependency treatment facilities it licenses, reports 292 licensed and/or Certificate of Need (CON) approved beds in FY 2009 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

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

*Note to Reader: This section is being updated and will be move to Section I of the Plan.*
Health/Medical/Dental Services are addressed by community mental health centers with other support services to adults with serious mental illness as part of local CSP plans, which are required as part of local providers' applications for CMHS block grant funds. CMHCs provide medical and dental services in a variety of ways, with the primary avenues being: 1) use of community health centers; 2) use of State Department of Health county health offices/services; 3) pro bono work by physicians and dentists; 4) University Medical Center services; 5) contributions by mental health associations and other local nonprofit/charitable organizations; 6) emergency medical/dental funds maintained by the provider program, including DMH funding for purchase of psychotropic medications; and 7) contributions by individuals and businesses. Of course, some medical and dental services are paid through the Medicaid and Medicare programs. Specific examples of medical/dental services reported as provided/accessed in FY 2009 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, private psychiatric hospitals, local private practitioners (medical, dental 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, the University of Tennessee School of Dentistry, and the University of Mississippi Medical Center, School of Dentistry.

As mentioned, outpatient health and medical care is also available through federally-funded Community Health Centers in the state. There are 21 Community Health Centers, with over 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, and provide services in a linguistically and culturally appropriate manner. 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 40% of health center adult 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 nationally. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration’s Bureau of Primary Health Care, fulfilling President Obama’s Growth Initiative for Community Health Centers. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.
The MS Department of Health (MSDH) also makes available certain specialized health care programs, such as: Home Care Services for homebound individuals requiring intermittent professional health services while under a physician’s care; WIC, the Special Supplemental Nutrition Program for Women, Infants and Children; the Breast and Cervical Cancer Early Detection Program, offering screening to uninsured, underinsured and minority women within specified age ranges for screening; the Domestic Violence/Rape Prevention and Crisis Intervention Program, providing resources through contracts with domestic violence shelters and rape crisis programs, including educational resources; the Family Planning Program; Maternity Services, targeting pregnant women whose income is below 185 of poverty and including special initiatives such as the Perinatal High Risk Management/Infant Services System and the Pregnancy Risk Assessment Monitoring System (PRAMS). Through other internal programs and community initiatives, MSDH works to address issues such as teen pregnancy, tobacco use, and unintentional injuries, and to promote specific interventions to decrease infant mortality.

As described previously, in order to receive CMHS funds and other funds administered by the DMH, all 15 mental health centers are required to develop a plan for providing community support services. This plan is developed using an outline of components that includes a requirement for local programs to describe how the program assures that consumers in all geographic areas have access to medical/dental services, how those services are paid for and how those services are provided in a timely manner. When the plans are submitted, they are evaluated by a committee convened by DMH, which includes family members, and corrections must be made until the state is satisfied that the plan adequately addresses requirements in the plan guidance. Annually, each CMHC submits a plan for providing medical, dental and other support services as part of their community support programs plan, which is required as part of the centers’ application for CMHS Block Grant funds. In FY 2009 and FY 2010, the Department of Mental Health continued to require that the 15 community mental health centers implement plans for providing medical, dental and other support services. This plan is submitted to the DMH with the services providers’ CMHS Block Grant funding request. The community mental health centers maintain a list of resources to provide medical/dental services, such as general health services, inpatient hospital, preventative, family support immunizations, TB screening, home health services, psychiatric evaluations/medication monitoring and communicable disease evaluation. The Department of Mental Health will continue this requirement in FY 2011.

Social Services

Note to Reader: This section is being updated and will be moved to Section I of the Plan.

Social Services and Financial Assistance are available through programs administered by the Mississippi Department of Human Services (DHS) for families/children who meet eligibility criteria for those specific programs. The DHS Division of Family and Children’s Services provides child protective services, child abuse/neglect prevention, family preservation/support, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The DHS Division of Family and Children’s Services and the Division of Youth Services work closely with the Department of Mental Health through participation on the MS State Mental Health Planning Council, MAP teams and other committees. The DHS Division of Economic Assistance provides Temporary Assistance for
Needy Families (TANF), TANF Work Program, Health Marriage Initiative, Supplemental Nutrition Assistance Program (SNAP), the Emergency Food Assistance Program (TEFAP), SNAP Nutrition Education, and the “Just Wait” Abstinence Education program. The DHS Division of Youth Services provides counseling, delinquency probation supervision and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, and oversees the state training schools. The DHS Division of Child Support provides child support location/enforcement services, and non-custodial visitation programs. The DHS Division of Children and Youth provides certificates for child care services for TANF clients, child welfare clients and some working foster parents. The DHS Division of Aging and Adult Services (DAAS) plans, advocates for, and coordinates the delivery of services to adults 60 years of age and older through a system of local Area Agencies on Aging (AAAs). The DAAS’s goal is to provide support services to help people remain in their own homes and local communities. The DAAS developed a single point of entry system for the aged and adult population with disabilities: the Aging and Disability Resource Center, called Mississippi Get Help. The project was piloted in central Mississippi and is scheduled to expand statewide with a toll-free, telephonic, virtual web-based, and face-to-face resource center that provides access to information, as well as assistance in applying for services. The “no wrong door” approach assures the public consistent information and assistance. In addition, it helps the public navigate through what can seem like a maze of government assistance, as well as the private and nonprofit service system. The Division of Aging and Adult Services also investigates abuse, neglect and exploitation of vulnerable adults, ages 18 and older in private settings under the Adult Protective Services program. The DHS Division of Community Services provides services such as the Fatherhood initiative, homeless resource referrals and low-income utility assistance. Additional social services and financial assistance are accessed as needed for adults with serious mental illness and are administered through various public service agencies/organizations, such as the MS Department of Human Services (described above), the Division of Medicaid, the Department of Health, the Social Security Administration, the Cooperative Extension Service, the Salvation Army, churches, etc. Examples of this assistance include SNAP benefits, medical/other financial assistance, nutrition services, protective services, transportation, financial counseling, etc.

Mental Health Case Management Services

Target Population: The following individuals with serious mental illness must be evaluated for the need for case management and provided case management if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated:

· Adults who have a serious mental illness and who receive substantial public assistance (defined as Medicaid); and,

· Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility.

Model of the Case Management System

The philosophy of the Mississippi Department of Mental Health Case Management System is that the provision and coordination of services are an integral part of aiding eligible recipients to gain access to needed medical, social, educational, and other services in order to reach and
maintain their highest level of independent functioning. The purpose of Case Management is to assist the consumer in achieving and maintaining the highest possible degree of personal growth, autonomy, and community integration. Responsiveness to persons with severe mental disabilities is maximized through a supportive relationship with a case manager. Inherent in this philosophy are the following principles: Entitlement, Empowerment, Environment, Relationship, and Community.

The DMH requires all CMHCs and community services divisions of the state psychiatric hospitals to offer 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 diversion from hospitalization, particularly for those individuals with high inpatient recidivism rates. In FY 2009, DMH-certified programs reported providing case management services to 15,811 adults with serious mental illness. DMH also provides funding to support for intensive case management programs targeting services to those individuals with the most severe need (i.e., individuals with a co-occurring disorders, individuals referred for civil commitment, those at high risk of rehospitalization, etc.) will help reduce their risk for hospitalization/rehospitalization. The funds support community mental health center staff maintaining supportive contact with consumers and participating in hospital discharge planning to assure a smooth transition from inpatient to community services settings.

In efforts to offer an array of service options to maintain individuals in their community, DMH offers additional case management service options for certification, such as:

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

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

Currently DMH is in the process of drafting updated *Rules and Regulations for the Case Management Certification Program*. The DMH Division of Professional Licensure is researching programs offered by other state licensure boards. DMH intends to pilot an online
self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program. The new internet-based staff training and development program has been implemented. Elevate powered by essential learning is a customized training website that tracks staff training. The Essential Learning training website will take the place of case management orientation and eliminate the need for extensive travel for case management. Providing the case management training program online will provide cost savings to the state, as well as to service providers.

In FY 2009 and FY 2010, case management records continued to be reviewed for meeting the requirement to evaluate adult with serious mental illness who receive substantial public assistance for the need for case management services. As of mid-2010, 100% of the records reviewed reflected that this requirement had been met, that is, there were no citations issued regarding the requirement that individuals with serious mental illness receiving substantial public assistance had case management explained, offered and refusal placed in writing.

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

Technical Assistance to Case Managers

Technical assistance for case management services for adults with serious mental illness is available through a designated staff member of the DMH Division of Community Services and through the Case Management Task Force, which meets to discuss changes and improvements to the system.

By March 2010, the Department had conducted/facilitated two Case Management Task Force meetings for FY 2010 (October, 2009 and January, 2010). The following topics were discussed: overview of the DMH Strategic Plan/Mental Health Service Delivery System Transformation Approach; Home and Community Based Waiver Update and availability of services information; and, an overview of wrap-around services. The Case management task force will continue to meet in FY 2011 and address needs as they arise/pertain to case management.

Case Management Outreach

In FY 2010 and FY 2011, the Department of Mental Health will continue to disseminate brochures about case management to the community mental health centers and Community Services Divisions of MS State Hospital and East MS State Hospital for use in public education/out reach activities.

See also objective on Case Management Training and objective on development of the Case Manager Certification Program under Criterion #5 that follows.

Activities to Reduce Hospitalization

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

Although all community-based services are aimed at preventing hospitalization, when possible, and reducing the rate of rehospitalization, some specific services are key components of community-based systems used as alternatives to inpatient treatment in the event of a crisis, as well as follow-up services once crisis situations have been stabilized. Efforts to improve the emergency response/crisis management systems to improve discharge planning and continuity of care and to provide training on evidence-based practices, such as integrated treatment for co-occurring disorders of mental illness and substance abuse.

Pre-evaluation Screening for Civil Commitment services, a major purpose of which is to reduce the number of inappropriate admissions to the state psychiatric facilities, is available through all 15 CMHCs. In providing assistance to the courts and other public agencies, community mental health centers screen area consumers who are being considered for referral to a state psychiatric facility for inpatient treatment in order to determine the appropriateness of such referrals. (See also section on Training of Pre-Evaluation Screening for Civil Commitment under Criterion 5.)

Emergency Response/Crisis Management Services

The Department of Mental Health Minimum Operational Standards for Community Mental Health/Mental Retardation Community Services require that certified community mental health centers have written policies and procedures for referral to inpatient services in the community, should an individual require such services. According to DMH minimum standards, providers must have current written agreements with licensed hospitals on file that: identify the mental health program’s responsibility for the consumer's care while he/she is in an inpatient setting; describe the services the hospital will make available to individuals who are referred; and, describe how hospital referral, admission and discharge processes are coordinated with emergency, pre-evaluation screening, and aftercare services. DMH is in the process of revising the DMH Minimum Standards, and although it is projected that the revised standards will be finalized by the end of the year, they are still in the draft stage. The emergency response/crisis management service requirement has been revised to reflect a seamless system that is readily available and easier for individuals in crisis to access and navigate.

The two major components of existing emergency services available through the 15 CMHCs are a crisis telephone service and when needed, availability of face-to-face contact with a mental health professional. Through the emergency service component, individuals for whom outpatient services are inadequate are often identified. Community mental health centers maintain agreements with local hospitals which, within certain restrictions, are able to treat individuals in lieu of admission to the state hospital. CMHCs might provide professional back-up to hospital staff to further ensure appropriate care. These agreements, however, are in many instances limited. For example, in some regions, the agreement is for general hospital beds on a priority basis, but the beds are in a general ward and no psychiatrist is on the hospital staff. In these instances, the admission may be made by a local private physician, and the mental health center staff work with the physician on a consulting basis. Recognizing that inpatient care is limited because of a lack of psychiatrists and available psychiatric beds and that inpatient hospitalization can be avoided in many if not most instances if intensive crisis intervention
services are readily accessible, the DMH has initiated development of crisis services across the state.

Regional Acute Care/Crisis Stabilization System

To address the need for more immediate access to emergency or crisis services, including acute hospital and crisis stabilization services closer to consumers’ home communities and their families, the State Legislature has funded major components to build a regional system to address the need for more immediate access to emergency or crisis services closer to consumers’ homes, communities, and their families. Regionalization of acute care/crisis stabilization services closer to individuals’ home communities will facilitate families’ participation in consumers’ treatment and transition from the hospital and reduce hospitalization and rehospitalization. As these regional service options become available, it is anticipated that the need for continued treatment beds at the two larger existing hospitals will be further reduced. These efforts also address the issue of waiting lists for admission to the larger existing state hospitals at Meridian (East MS State Hospital) and at Whitfield (Mississippi State Hospital).

Inpatient services for adults with serious mental illness are currently available statewide through two comprehensive state psychiatric hospitals (Mississippi State Hospital, which historically has served 51 counties, and East Mississippi State Hospital, which has served 31 counties) and on a limited basis through local public or private hospitals. North MS State Hospital and South MS State Hospital, both 50-bed units, provide acute psychiatric services for adults. These two hospitals are designed to provide more immediate access to acute care services, which are anticipated to reduce the need for longer-term stays or continued treatment at the two larger state hospitals in Meridian and Whitfield. Services provided through these two units are coordinated with community mental health center services in their respective regions to facilitate continuity of care before admission and after discharge, thereby further reducing the need for rehospitalization. The goal of both Mississippi State Hospital and East Mississippi State Hospital is to make available quality inpatient services for individuals in need of this level of care, when such services are not available at the local levels.

 Provision of more immediate access to crisis services for short-term emergency mental health treatment, for serving persons awaiting commitment proceedings or awaiting placement in a state mental health facility following commitment and for diverting placement in a state mental health facility was a major provision in the 1997 Mental Health Reform Act (SB 2100). Also included in the legislation was a provision to establish regional state offices to provide mental health crisis intervention centers and services to be used on a case-by-case emergency basis. The 1999 State Legislature provided funding for construction of seven community-based crisis centers to be operated as satellites of existing and new facilities operated by the Department of Mental Health. Due to limited funding availability, operational funding was provided over the next five to 10 years.

In FY 2009 the Mississippi Legislature approved the Department of Mental Health Crisis Center Redesign Plan, permitting DMH to transition the operation of one of the seven state-operated crisis intervention centers from Mississippi State Hospital to operation as a crisis stabilization unit by Life Help Community Mental Health Center. This pilot program, located in Grenada, was operated under the Department of Mental Health’s community mental health minimum standards for intensive residential programs, rather than under state standards for psychiatric hospitals, which allowed for more progressive programming and resulted in cost reduction. In
FY 2010 DMH sought and received legislative approval to transition the remaining six state-operated units 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 crisis stabilization units (in Batesville, Brookhaven, Cleveland, Corinth, and Laurel); Central Mississippi Residential Center will continue to operate the unit in Newton. The Division of Community Services continues to provide State funding for Crisis Stabilization Units that operate under Intensive Residential Facility standards. These programs are intended to provide immediate care to individuals in acute crisis. Before FY 2010, DMH funded three Intensive Residential Facilities in Region 6, 13, and 15. In August 2010 (with permission from DMH) Region 15 closed its Intensive Residential Facility and utilized the funds to begin a PACT team. Region 6 opened a 16-bed intensive residential program in September 2009. Region 6 continued to operate both intensive residential programs until February 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. The operation of all seven units will be based on the redesign piloted at the center in Grenada, which as mentioned, includes operation based on community-based standards for intensive residential programs and acute partial hospitalization services. The units will serve adults who are admitted on both an involuntary and voluntary basis.

### Intensive Case Management

Since FY 2000, the DMH has continued support (including support from the CMHS Block Grant) of the development of comprehensive emergency services systems, of which intensive case management is an important component. In FY 2009 and FY 2010, the DMH continued the support of comprehensive emergency service systems, of which intensive case management is an important component.

### Other Intensive Residential Treatment Programs

Additionally, the DMH will continue to provide funding to help support two intensive residential treatment programs for adults with serious mental illness in crisis (in addition to the crisis centers described previously): one will continue, operation in Vicksburg, by Region 15 CMHC (Warren-Yazoo Mental Health Services), and one will continue operation in Gulfport by Region 13 CMHC (Gulf Coast Mental Health Center). LifeHelp (Region 6) has integrated the five-bed intensive residential treatment program it operated previously in Greenwood with the crisis stabilization unit in Grenada. Region 13 (based in Gulfport) continues to operate an intensive residential treatment facility in Harrison County. Region 15 (Vicksburg/Warren Counties) opened its intensive residential treatment facility in Vicksburg in July 1998, initially taking voluntary admissions. In October, 1998, they also began serving
individuals who had been or were involved in the civil commitment process. The intensive residential treatment facility provides the residential component, while Warren County provides the holding facility component in a separate location. Since opening, the intensive residential treatment facilities in Region 13 and Region 15 have reported a positive impact on diverting individuals from state psychiatric hospital admission.

**National Outcome Measure: Evidence-Based Practice – Assertive Community Treatment**
(URS Developmental Table 16)

**Assertive Community Treatment** is an evidence-based practice included in the CMHS Core Performance Indicators, the proposed definition of which differs from intensive case management, but which also includes a target population of individuals with more severe and persistent challenges. As mentioned previously, the Person-centered Planning project implemented in four regions targeted individuals at risk for hospitalization or rehospitalization, and is exploring using a more team-oriented approach to transition planning, which is one element of the proposed federal definition of Assertive Community Treatment. In May 2005, staff from the DMH Division of Community Services attended the Annual Assertive Community Treatment (ACT) Conference in Tampa, Florida. Technical assistance on ACT was provided in 2006, through support/collaboration with NAMI-MS; the role that peer specialists might play in provision of ACT services has also been explored. Since that time, DMH Division of Community Services staff has visited with staff of the VA Hospital’s ACT team in Jackson. Staff from Region 15’s community mental health center have visited the ACT team in Little Rock, Arkansas (in March 2007), and the DMH sent a team (that includes regional staff that participated in the PCP project) to Oklahoma at the end of FY 2007 to obtain additional, follow-up technical assistance regarding implementation of ACT. Since that time, an ACT Steering Committee has been established to continue work on development of ACT and efforts have continued to seek funding support for ACT teams. DMH continued activities through its Data Infrastructure Grant (DIG) Quality Improvement project to develop the capacity of the central data repository system for data collection and reporting of evidenced based practices, such as assertive community treatment. In 2009, DMH staff and staff representatives from Region 6, Life Help CMHC traveled to Tulsa, Oklahoma to receive training in the PACT model. In April, 2010, the PACT Coordinator from Oklahoma came to Greenwood, MS, to provide onsite technical assistance. Life Help has PACT staff hired and projects that it will begin serving individuals in July 2010. The Division of Community Services began pilot funding and development of a Program of Assertive Community Treatment (PACT) in Region 6 (Greenwood) and are currently in the process of developing a second PACT team in Region 15 (Vicksburg). The Division of Community Services continues to work with the Division of Medicaid to develop a reimbursement structure for PACT services.

**Priority Area#8: Comprehensive Community-Based Mental Health Systems for Adults**

**Goal:** Decrease utilization of state inpatient adult psychiatric services

**Strategy:** DMH will continue to track the rate of inpatient readmissions within 30 days and within 180 days

**Performance Indicator:** Ratio of civil readmissions to civil discharges at state hospitals within 30 days and within 180 days.
Description of Collecting and Measuring Changes in Performance Indicators: Uniform Reporting System (URS) tables, including URS Table 20 (Rate of Civil Readmission to State Inpatient Psychiatric Facilities within 30 days and 180 days)

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. As mentioned previously, the DMH is working through its CMHS Data Infrastructure Grant project to address issues regarding data collection on this and other national outcome measures. 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 is continuing work to develop capacity to collect data from all funded/certified providers 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 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. Collaborative efforts to increase continuity of care across hospital and community services settings and increased focus on the provision of community-based services, including more timely access to crisis stabilization services are designed to prevent hospitalization and rehospitalization.

Action Plan: The Department of Mental Health will implement initiatives to provide community-based crisis stabilization services, to improve discharge planning and continuity of care for individuals transitioning from inpatient to community-based care, and to provide training on evidence-based, integrated treatment for persons with co-occurring disorders, which are described in the State Plan.

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)

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2012 Target</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td></td>
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</tr>
<tr>
<td>1. Decreased Rate of Civil Readmissions at state hospitals within 30 days</td>
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<td></td>
</tr>
<tr>
<td>Numerator: Number of civil readmissions to any state hospital within 30 days</td>
<td>4.12%</td>
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<td>3.4%</td>
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<tr>
<td>Denominator: Total number of civil discharges in the year</td>
<td>175</td>
<td>106</td>
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<tr>
<td>2. Decreased Rate of Civil Readmissions at state hospitals</td>
<td>15.62</td>
<td>14.7%</td>
<td>15.3%</td>
<td>14%</td>
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</table>
Mississippi

<table>
<thead>
<tr>
<th>within 180 days</th>
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<tbody>
<tr>
<td>Numerator:</td>
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<td></td>
</tr>
<tr>
<td>Number of civil</td>
<td>663</td>
<td>524</td>
</tr>
<tr>
<td>readmissions to</td>
<td></td>
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</tr>
<tr>
<td>any state hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>within 180 days</td>
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</tr>
<tr>
<td>Denominator:</td>
<td>4244</td>
<td>3552</td>
</tr>
<tr>
<td>Total number of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>civil discharges</td>
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<tr>
<td>in the year</td>
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Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

**Goal:** To reduce involvement of adults with serious mental illness in the criminal justice system.

**Strategy:** Continue tracking the 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.

**Performance Indicator:** 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 (T2).

**Description of Collecting and Measuring Changes in Performance Indicator:** 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.

**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.
Mississippi

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 (105 in 2009) 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 prior to 2009 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. Although increasing the survey sample size in 2009 increased the total number of responses, the number responding to this survey remains low in comparison to the total number of individuals responding to other survey items.

Significance: The Department of Mental Health will continue to explore other funding sources 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: Because of budget restrictions, DMH will not continue funding support of law enforcement training provided by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers explore other avenues 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, such as described under Criterion 5.

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>% age of adult consumers Arrested in Year 1 (T1) who were not rearrested in Year 2 (T2)</td>
<td>69%</td>
<td>64%</td>
<td>68%</td>
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</tr>
<tr>
<td>Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)</td>
<td>75</td>
<td>18</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Denominator: Total number of adult consumers arrested in T1 (new and continuing clients combined)</td>
<td>108</td>
<td>28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health Transformation Activity: Improving Coordination of Care among Multiple Systems**

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

Implementing a strategic plan to better address the needs of individuals with co-occurring disorders of mental illness and substance abuse is a major task in system transformation efforts. The DMH has pursued initiatives to improve services in this area for many years; most of these efforts were coordinated by what was formerly the Dual Diagnosis Task Force, which was restructured to become the Co-occurring Disorders Coordinating Committee.

The Co-occurring Disorders Coordinating Committee functions to identify needs and plan for improvements to services for individuals with co-occurring disorders of mental illness and substance abuse and sponsored an annual conference addressing specific training issues in this area for both adults and children and developed program guidelines for grants to local providers to provide specialized services for individuals with co-occurring disorders.

In April 2005, the DMH received technical assistance from the Center for Excellence on Co-occurring Disorders, sponsored by SAMHSA, which focused on issues pertinent to service planning for adolescents and young adults with co-occurring disorders. DMH’s planning efforts were expanded to address the need for a more comprehensive, integrated systems approach across all age groups. As part of that effort, the DMH provided inservice training to state office staff and disseminated SAMHSA’s *TIP 42 (Treatment Improvement Protocol)* to substance
abuse and mental health community services providers throughout our state. In February 2006, DMH utilized its Annual State Conference on Co-occurring Mental Health and Substance Related Disorders to further engage additional stakeholders in planning efforts and to advance knowledge in the field about the evidence for service integration. These focused activities over approximately one year culminated in the development of a draft Strategic Plan for Co-occurring Disorders, developed by a group of stakeholders that included state office staff across divisions, local service providers and a consumer representative; this planning session was facilitated once again by the COCE. DMH also submitted an application to SAMHSA for a Co-occurring Disorders Transformation Grant in 2006; however, its proposal was not funded. The Co-occurring Disorders Coordinating Committee was reconvened in FY 2007 to review, refine and address objectives in the plan. Additional Technical assistance from COCE was received in 2007 to continue progress on implementation of evidence-based integrated service models. The Co-occurring Disorders Coordinating Committee met in April 2008 and developed subcommittees on workforce development, treatment plan training and screening and assessment. A committee member attended a national training program on TIP 42, and three committee members attended training on the GAIN (standardized assessment instrument). In FY 2009, statewide training sessions were initiated to facilitate implementation of integrated treatment for persons with co-occurring disorders. As of April 2009, staff from Region 12 (Pine Belt Mental Healthcare Resources) was provided consultation, training, and clinical coaching on co-occurring disorders to all 15 the community mental health regions. Formal training is offered on assessment, reporting of diagnosis, treatment planning, for individuals with co-occurring disorders, and including evidence-based practices for providing services to individuals with co-occurring disorders and effective clinical supervision for enhanced clinical outcomes. To date, training has been provided in four regions. As of In February 2009, a standardized screening instrument, the GAIN, has been implemented in all regions. The Department of Mental Health received funding from the Center for Mental Health Services for the Transformation Transfer Initiative (TTI), one component of which was designed to support continued training of mental health providers in assessment and treatment of co-occurring disorders. By mid-year in FY 2010, Three trainers had been identified to provide the training to staff in community mental health regions and from state hospitals who were not trained in FY 2009. Coaching and technical assistance were also provided to all 15 regional community mental health centers and to four state hospitals following the training. The training throughout the state was completed in September of 2011. is projected to be completed by April of 2011.

Priority Area#8: Comprehensive Community-Based Mental Health Systems for Adults
This goal also addresses Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

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

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

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

Population: Adults with Serious Mental Illness

Criterion: Comprehensive, community-based mental health services

Brief Name: Co-occurring Disorders Coordinating Committee Operation

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

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

Source(s) of Information: Co-occurring Disorders Coordinating Committee minutes

Special Issues: None

Significance: The DMH allocates funds specifically for the provision of community-based services for individuals with co-occurring disorders. The committee continues to work on identifying and addressing services improvements.

Funding: Federal (CMHS) funds

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

Public Resources

Mental Health Transformation Activities: Consumer and Family Operated Programs and Involving Consumers and Families in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)

Local Advisory Committees

The MS Department of Mental Health Minimum Standards for Community Mental
Health/Mental Retardation Services require community service providers to have an individual/family advisory committee to advise the governing authority of the local provider entity on matters related to individual/family satisfaction, annual operational plans, performance outcomes, program planning and evaluation, quality assurance/improvement, type and amount of services needed and other issues the advisory committee chooses to address. The committees must include family members and individuals served by the provider, as well as other interested individuals, with representation commensurate with the major services provided by the organization (e.g., mental health services, substance abuse services, visits). Compliance with this requirement continues to be monitored by DMH staff on certification/site visits. As part of a comprehensive review of DMH Minimum Standards, in FY 2008, the new Division of Family and Consumer Affairs in the DMH Bureau of Community Services undertook a review of the role of consumers and family members on local advisory councils in Mississippi and in other states and subsequently initiated activities in FY 2009 to improve the effectiveness of the councils. Based on the review, the Division has proposed changes to the Mississippi Department of Mental Health Minimum Standards for Community Mental Services that, if enacted, will provide more specific guidance regarding the purpose and structure of local advisory councils. The Division has also developed a draft of a toolkit to provide technical assistance to the local advisory councils and plans to develop strategies for dissemination of educational information to the local councils in FY 2010. In FY 2010, 2012 the Division will continue to work on encouraging dialogue with and among state advisory councils to assess strengths and needs and supporting local advisory councils based on feedback using the Advisory Council Guide, developed by the Division as a technical assistance tool. The Division will continue to disseminate educational information to the local councils in FY 2011.

Division of Consumer and Family Affairs

Since FY 2007, DMH has employed consumers to work part-time in the state office to assist with the peer review process and consumer educational events, as well as to facilitate planning and development of a peer specialist program and employment opportunities. In FY 2008, the DMH established the Division of Family and Consumer Affairs (DCFA) in the Bureau of Community Services, which assumed these responsibilities, as well as oversight of family education programs and drop-in center services. Operational objectives of the division include:

- To ensure that individuals and families are the driving force for improvements in the publicly funded mental health system;
- To help individuals and their families participate in decision-making at all levels of the public mental health system; and,
- To promote the empowerment of individuals and families with mental health needs through education, support and access to mental health services.

In April 2008, the Division of Consumer and Family Affairs DCFA convened a preliminary workgroup of consumers, family members, and service providers representatives and began to begin work to gather additional input for further development of the goals and objectives of the new Division. By consensus, the preliminary workgroup generated the following suggestions, that which continue to guide the work of the Division, were generated:
Mississippi

- Ongoing education of stakeholders, including leadership at the local and state levels, about the importance of consumer and family involvement in services, what that involvement should include;
- Ongoing outreach to build capacity of consumer and family education programs;
- Refinement and education about the role of local advisory councils; and,
- Continued evaluation and refinement of the peer review process.
- Improving coordination of activities designed to increase consumer and family inclusion.

In FY 2011, the Council on Quality Leadership’s (CQL) Personal Outcome Measures 2005© became the foundation for the peer review process. was replaced with the. The Council on Quality Leadership is an international not-for-profit organization dedicated to being the leader for excellence in the definition, measurement, and evaluation of personal and community quality of life for people with disabilities and people with mental illness. Personal Outcome Measures are a tool for evaluating personal quality of life and the degree to which organizations individualize supports services to facilitate better outcomes. People define outcomes for themselves. Personal outcomes are important because they put “listening to” and “learning from” the person at the center of organizational life.

In FY 2009 and in FY 2010 In FY 2012, the Division of Consumer and Family Affairs’ (DCFA) will continue to develop strategies to facilitate the transformation to a person-driven, family-centered, community-based, results and recovery/resiliency oriented recovery orientation mental health system. Activities currently being considered include the development of an education and information campaign focused on disseminating information about recovery and empowerment; training all DMH service providers recovery model, person-centered planning, and System of Care principles/values and identification collaborating of possible avenues with other at the state and local level entities for further to promote recovery-oriented systems change. (e.g., through existing advisory councils, committees and task forces). Additionally, in FY 2011, 2012 the Division will continue facilitating the incorporation evidence based recovery/resiliency practices and procedures across Bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers, and to examine strategies that have been successful in other states in promoting recovery and consumer empowerment.

Development of Peer Specialist Services

Since 2006, the DMH has received technical assistance and training on planning for development establishing of peer specialist services in the state (based on Georgia’s model). A Peer Specialist training session in the fall of 2006 involved individuals receiving services, family members, and service providers in training regarding the peer specialist program and the recovery model. In FY 2008, one of the consumers employed by the DMH in the Division of Consumer and Family Affairs completed the one-week Certified Peer Specialist Training in Kansas. In March, 2008, staff from the Division of Consumer and Family Affairs as well as local provider and NAMI-MS representatives visited the Georgia Peer Support program in Georgia and received technical assistance on program development from certified peer specialists, Medicaid representatives, and Georgia Department of Mental Health staff. Activities to develop peer specialist services continued in FY 2009. In May 2009, the first group of 16
interested consumers received training in the provision of peer specialist services, based on the Georgia model, and a workshop for providers interested in peer specialist services was provided as part of the 2009 Mental Health Community Conference and in FY 2010, two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. Certified Peer Specialists have been working to establish bylaws, goals and a mission statement for the Mississippi Peer Leadership Network, a newly formed consumer coalition.

In FY 2012, the Division of Family and Consumer Affairs plans to continue activities to advance the development of peer specialist support services in Mississippi, by focusing on the provision of education to service providers about the definition and role of Peer Specialists services in a recovery-oriented system in the recovery process. The Bureau of Community Services will also continue efforts to obtain funding support to employ and/or provide peer specialist services training. Currently Certified Peer Specialists are working to establish bylaws, goals and a mission statement for Recovery Now, a newly formed consumer coalition. In FY 2010 two Certified Peer Specialists were employed as a part of the Assertive Community Treatment Team in Region 6. In FY 2011-2012, the Bureau of Community Services will continue to explore areas to employ Peer Specialists and educate community mental health systems on the role of Peer Specialists in the recovery process. In April 2010, DMH applied for funding through SAMHSA to develop Peer Specialist employment and education opportunities for an increased number of consumers; however, as of early June notification of the grant review had not been received by DMH.

Development of Statewide Consumer Coalition

In FY 2010, the Division of Consumer and Family Affairs and the Division of Community Services continued to facilitate development of an independent statewide consumer coalition. Discussions with interested stakeholders about the potential to develop an independent consumer coalition were held in conjunction with the May 2009 Community Mental Health Conference and facilitated by the National Consumer Empowerment Center. In FY 2010, the Division of Family and Consumer Affairs collaborated with other groups to identify consumers interested in assuming leadership roles in developing a statewide consumer coalition and by seeking guidance on steps to move forward in forming and supporting the coalition., possibly through holding a retreat of identified consumer leaders to discuss forming and supporting a coalition. Through this effort, consumer coalitions were developed in the north and south. The Consumer Coalition of the South meets monthly. Efforts are being made to develop a consumer coalition in the central part of the state. In FY 2011, 2012 the Division of Consumer and Family Affairs will continue to work with the newly formed consumer coalition groups, Recovery Now, by providing requested support and technical assistance.

Protection and Advocacy

Disability Rights Mississippi is a private, nonprofit corporation established to protect and advocate for the rights of individuals with disabilities through negotiation, legal, and administrative remedies. Disability Rights Mississippi is independent of any agency, organization or governmental unit providing treatment, services, or habilitation to individuals with disabilities. The staff is also responsible for providing public information concerning the
The purpose of Mental Health Advocacy Services within Disability Rights Mississippi is to protect and advocate for the rights of persons with mental illness. Services provided through the program include information and referral; technical assistance; advice and support for persons who plan to advocate for themselves, their rights and needed services; assistance in meetings and negotiations; representation in administrative appeals and hearings; and litigation of cases, where the outcome could benefit many individuals. Additional services designed to enhance the rights of all persons labeled mentally ill include: public information and education regarding the needs and rights of persons labeled mentally ill; monitoring of state institutions and private and public psychiatric hospitals; and identification of problems in the system of service delivery and advocacy to improve the service delivery system. It provides advocacy and legal assistance to persons with mental illness living in a variety of settings, including jails, personal care homes, detention facilities, group homes, nursing homes and those living independently.

Family Education/Support and Consumer Education Support Programs are designed to address three of the major risk factors found to be associated with rehospitalization of individuals at the largest state psychiatric facility: medication non-adherence, current alcohol use (specifically as it affects individuals with mental illness), and family conflict (including education about serious mental illness and skills needed for effective communication among family members and consumers). The DMH Division of Community Services adopted the Family-to-Family education program, which is conducted by family members, for implementation of the community mental health system’s family education component in FY 2000. The Department of Mental Health provides funding to NAMI-MS to make the “Family to Family” education program available to CMHC regions.

The CMHCs are asked to provide support to NAMI-MS in implementing the family education/support program, through such activities as identifying potential participants, providing meeting space if needed, and/or helping to develop a media campaign to advertise the availability of the program. Under current minimum standards, DMH staff monitor local programs for increased documentation of the types of support provided to family education programs. This requirement was added to help increase the availability and uniformity of family education/support programs across the mental health regions in the state. As of June 2010, NAMI-MS had served 44 family members in Family to Family classes. The target for FY 2010 was modified from 70 to 60. Two to three additional training sessions will be scheduled before the end of FY 2010; however, based on the average number of people attending the first three classes in FY 2010 (which was 44), the overall target for FY 2010 was reduced.

For FY 2011, the specific objective for the provision of family psychoeducation was deleted because of a reduction in state funding. DMH will continue to provide federal CMHS Block Grant funds to NAMI-MS, which plans to focus efforts on enhancing the role of affiliates in providing education and support for families and consumers. It is projected that this decentralization will result in a more responsive system. NAMI-MS will also spend time
developing an ideal NAMI system model for the state and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education and support.

**Provider Education**

In FY 2003, NAMI-MS initiated the NAMI Provider Education Program in Mississippi. This is a 30-hour course in mental illness education and consumer/provider/family collaboration skills for line staff at public mental health agencies. The five-member training groups include two consumers, two family members and a mental health professional who is also a family member or consumer. As of April 2009, the NAMI Provider to Provider program had been offered at CMRC; 18 providers were trained during the four-day course. Due to budgetary restraints in FY 2010, NAMI did not conduct any Provider to Provider trainings, and NAMI does not plan to conduct Provider to Provider trainings in FY 2011.

**Consumer Education/Support Programs**

The Mississippi Leadership Academy (MLA) resulted from a federally funded grant designed to enhance leadership and communication skills of persons with a serious mental illness. Since it was first instituted in Idaho in the early 1990’s, over 20 states have become sponsors, with West Virginia having replicated the leadership academy model. The MLA is designed to be offered twice a year; its student body consists of individuals who are recovering from serious mental illness and who aspire to assume leadership roles in the mental health community, as well as in the community at large. Each class includes approximately 20 graduates. Persons who have participated in Peer-to-Peer training, BRIDGES training or who are interested in increasing their leadership skills will continue to be provided an opportunity to participate in the Academy, as resources are available. As a result of the skills individuals learn in the Peer to Peer classes, NAMI-MS has many consumers who now teach the course throughout the state. Others have represented NAMI Mississippi at the NAMI National Convention, held in various cities across years. Peer to Peer graduates also serve NAMI-MS statewide by presenting their personal stories about living with a mental illness as by serving as support group facilitators.

The Mississippi Leadership Academy (MLA) conducted two training sessions in 2008 and 2009, producing a total of 36 graduates. **The Mississippi Leadership Academy held a training session in December 2010.** The Director of the MLA has maintained contact with all graduates through a newsletter and personal correspondence. Many of them report their leadership involvement with mental health training programs throughout the state (NAMI Peer to Peer and In Your Own Voice; State Mental Health Planning and Advisory Council; Consumer Coalition conferences; peer reviews; and, peer advocacy). At least 14 of the graduates have assumed lead roles on the MLA planning team. Five graduates are advisory board members at local CMHCs, with others expected to assume similar roles during this fiscal year. The Director of the MLA continues to strengthen peer reviews, peer counseling and provider education. The 2009 curriculum promoted active consumer advocacy with regard to law enforcement education personnel and crisis intervention. Most students continue to be referred to the MLA by the regional CMHCs and the state NAMI office, however, and a few referrals have come from
private practitioners. The MLA continues to identify a liaison with the Veterans Administration to provide outreach to more potential MLA students from that arena. The MLA distributed its first newsletter in December 2008 and the Division of Consumer and Family Affairs is working with the state Information Technology Services (ITS) agency to enhance the website.

A significant step in converting the MLA to a consumer-led program occurred in February 2009, when the MLA Board was established. The Director of MLA is a consultant to this consumer-led board, which plans to assume total responsibility for teaching the curriculum by December 2010.

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 targeted number for FY 2010 for individuals to be served in the Peer to Peer Program was expected to decrease because of the loss of a Peer to Peer Coordinator position and reduced funding; however, given the additional individuals projected to receive illness self-management recovery services through CMRC’s program, the target remained the same for FY 2010. Three Peer to Peer trainings 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 session in Meridian, July 26-29, 2010). The Mississippi Leadership Academy has a training session scheduled for December 2010.

In FY 2011, the target for the following objective is being decreased due to a reduction in state funding, which supported the Peer to Peer component of the objective. DMH will continue to provide federal CMHS Block Grant funds to NAMI-MS, which plans to focus efforts on enhancing the role of affiliates in providing education and support for families and consumers. It is projected that this decentralization will result in a more responsive system. Additionally, NAMI-MS will spend time developing an ideal NAMI system model for the state and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education and support.

**Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults**

**Goal:** To provide family and consumer education and support.

**Strategy:** Information about the Mississippi Leadership Academy (MLA) will be made available to individuals with serious mental illness served through the public community mental health system.

**Performance Indicator:** The number of individuals who complete the Mississippi Leadership Academy (MLA)

**Description of Collecting and Measuring Changes in Performance Indicator:** Consumer education program records and grant program reports.
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 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 who complete the Mississippi Leadership Academy (MLA)

Source(s) of Information: Consumer education program records; Grant program reports

Special Issues: The Consumer Education Programs provided or supported through the CMHC must be NAMI Peer to Peer, the Mississippi Leadership Academy or other program approved by the DMH. 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, including reductions in FY-2010 and FY-2011 because of reduced funding, as previously described.

Significance: The Mississippi Leadership Academy is 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.

Action Plan: 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)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Actual</th>
<th>(4) FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Transformation Performance Indicator</td>
<td>Percentage of persons served who received illness management/recovery services*</td>
<td>.14</td>
<td>.08</td>
<td>.03</td>
</tr>
<tr>
<td>Numerator: Number Receiving Illness Management/Recovery Services*</td>
<td>73</td>
<td>40</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Denominator: Number of persons with SMI served (community services)</td>
<td>53,910</td>
<td>49,000</td>
<td>49,000</td>
<td>49,000</td>
</tr>
</tbody>
</table>

*In accordance with CMHS Reporting Guidelines for Evidence-based Practices, it should be noted that numbers reflect individuals served through programs that involve a specific curriculum: programs will include Peer to Peer, MS Leadership Academy and/or BRIDGES (through FY 2008).

Other Educational Opportunities

In April 2010, DMH applied for funding through SAMHSA to increase the number of services and supports for consumers and family members such as peer mentoring, peer coaching, support groups, and other educational activities, which would decrease the intensity of services needed for them to remain in their communities; however, as of early June notification of the grant review had not been received by DMH. Increasing an individual’s ability to remain in the community by strengthening community supports and individual resiliency are primary goals of the grant. The Peer Specialists would also be providing Wellness Recovery Action Plans to individuals with serious mental illness. The grant development task force agreed that both the Peer Specialist Program and the WRAP program complimented the goals and objectives of the initiative.

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To make available, through local, state or national media, education/training opportunities and materials

Strategy: DMH will continue to make funding available to support educational opportunities for consumers through local, state or national education/training opportunities.
**Performance Indicator:** DMH will continue to make opportunities available for consumers to participate in local, state, and/or national trainings and provide educational materials to on self empowerment, recovery, and/or illness management.

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

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

**Special Issues:** None

**Significance:** Continuing support of local, state and/or national education/training opportunities. Educational materials distributed will focus on recovery and empowerment, and will be shared with consumers of mental health services, as well as family members, mental health professionals and other interested stakeholders.

**Funding:** CMHS block grant

**Other Support Groups**

NAMI MS also continues to offer NAMI Connection groups in Jackson (two groups), Meridian, Greenwood, Oxford, Southaven, Vicksburg, Gautier, Gulfport, and Hattiesburg. A NAMI Connection Facilitator training is scheduled to be held in Jackson in August 2010. NAMI Connection Recovery Support Group is an alliance of adults who have in common the experience of living with mental illness. It provides a place to share experiences and use them as learning opportunities for themselves and others. Groups are offered free of charge, meet weekly and are led by trained individuals who are also in recovery.

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

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To increase social supports/social connectedness of adults with serious mental illness (i.e., positive, supportive relationship with family, friends and community)

Strategy: DMH will track the percentage of adults with serious mental illness served in the public community mental health system reporting positively regarding social connectedness.

Performance Indicator: Percentage of adults with serious mental illness served in the public community mental health system reporting positively regarding social connectedness.

Description of Collecting and Measuring Changes in Performance Indicator: 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.

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: DMH has worked with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the MHSIP Consumer Satisfaction Survey in FY 2006 - FY 2009 to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 11 submission and are reflected in the chart above. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008 survey was 15%.

Significance: Improving the social support/connectedness of adults with serious mental illness.
receiving services is a key indicator in assessing outcomes of services and supports designed to support individuals in taking a more active role in their recovery. Case management facilitates linkage of services/resources for individuals with serious mental illness, ensuring that an adequate service plan is developed and implemented, reviewing progress, and coordinating services.

**Action Plan:** The Division of Community Services and the Division of Family and Consumer Affairs will continue activities described in the State Plan that focus on the shift to a more person-directed system of care, such as continued support of illness self-management programs (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)**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% age of Families of adult consumers reporting positively regarding social connectedness</td>
<td>76%</td>
<td>73%</td>
<td>74%</td>
<td>72%</td>
</tr>
<tr>
<td>Numerator: Number of adult consumers reporting positively about social connectedness</td>
<td>1112</td>
<td>445</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of adult consumer responses regarding social connectedness</td>
<td>1470</td>
<td>607</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Goal: To increase satisfaction of adults with serious mental illness regarding their functioning

Strategy: Track the percentage of adults with serious mental illness reporting positively regarding functioning.

Performance Indicator: 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.

Description of Collecting and Measuring Changes in Performance Indicator: 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 DHM)

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.

Since FY 2007, DMH has continued to work with the University of Mississippi Medical Center, using part of its federal CMHS Data Infrastructure Grant (DIG), to partially support administration of the official version of the MHSIP Consumer Satisfaction Survey to a representative sample of adults receiving services in the public community mental health system. Results will continue to be included in the URS Table 9 submission and are reflected in the performance indicator table. The stratified random sample was increased to 20% from each community mental health region in the 2009 survey in an effort to increase the response rate to the voluntary survey in individual regions. The overall response rate for drawn for the 2008
survey was 15%.

**Significance:** Improving the functioning of adults with serious mental illness receiving services (from their perspective) is a key indicator in assessing progress on other goals designed to improve the quality of services and support recovery-oriented systems change.

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Indicator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% age of Families of adult consumers reporting positively regarding functioning</td>
<td>72%</td>
<td>71%</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Numerator: Number of families of adult consumers reporting positively about functioning</td>
<td>1053</td>
<td>433</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of adult consumer responses regarding functioning</td>
<td>1458</td>
<td>609</td>
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</tr>
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</table>

**Private Resources**
*(To be updated)*

Outpatient mental health services are also available through licensed practitioners in the private sector, whose scope of practice and services are regulated by their respective licensure boards/agencies and payors of their services. The Department of Health, which collects data on private psychiatric facilities it licenses, reported 535 licensed/inpatient beds, with an additional seven beds held in abeyance and 34 CON approved beds by MSDH in FY 2009 for psychiatric services for adults (excluding DMH hospitals and including 21 beds at University Medical Center). The MS Department of Mental Health does not collect data on inpatient hospitals; that
information is maintained by the MS State Department of Health, which licenses those facilities in the private sector.

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
<th>Target</th>
</tr>
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<tr>
<td>(1) FY 2009</td>
<td>(2) FY 2010</td>
<td>(3) FY 2011</td>
<td>(4) FY 2012</td>
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<tr>
<td>Performance Indicator</td>
<td>29%</td>
<td>29%</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>Numerator</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Denominator</td>
<td>7</td>
<td>7</td>
<td>7</td>
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</tr>
</tbody>
</table>

Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults

Goal: To promote use of evidence-based practices in the community mental health services system for adults.

Strategy: Provide information will be provided to maintain use of one evidence-based practice for adult services (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)

Performance Indicator: The number of evidence-based practices for adults with serious mental illness implemented.

Description of Collecting and Measuring Changes in Performance Indicator: Consumer education program (Mississippi Leadership Academy) records and grant program records

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 one evidence-based practice for adult services (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)
Mississippi

**Measure:** The number of evidence-based practices for adults with serious mental illness implemented.

**Sources of Information:** Consumer education program (Mississippi Leadership Academy) records (grant program records)

**Special Issues:** As noted previously, the objective to provide family psychoeducation services through NAMI’s Family to Family program was deleted for FY 2011 because of reductions in funding. 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 (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.

---

**Local Plans for Services for Elderly Persons**

Historically, a task force was established in 1989 to examine more closely the specialized needs of elderly persons with serious mental illness and to develop strategies to meet those needs for integration in the State Plan. Since that time, all 15 CMHCs have developed a local plan for services to elderly persons with serious mental illness utilizing a guide that emphasizes outreach, interagency coordination of services and case management. The Elderly Senior Adult Services Task Force was reconvened in November 2007 and met again in February 2009 and in March, 2010. By March, 2010 all 15 CMHCs had submitted local plans for elderly services.

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**Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults**

**Goal:** To provide community mental health and other support services for elderly persons with serious mental illness.

**Strategy:** Require a local plan for providing services to elderly persons with serious mental illness.

**Performance Indicator:** The number of CMHCs that submit a local plan for providing services to elderly persons with serious mental illness. (Minimum: 15)
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)

<table>
<thead>
<tr>
<th>PI Data Table A1.6</th>
<th>FY 2008 (Actual)</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Plans for Elderly Services</td>
<td>15 CMHC Regions</td>
<td>15 CMHC Regions</td>
<td>15 CMHC Regions</td>
</tr>
</tbody>
</table>

*Target modified due to Hurricane Katrina.

Source(s) of Information: Community Mental Health Center Local Plans for Elderly Services

Special Issues: None

Significance: The plans will indicate the services that are provided for elderly persons with mental illness in each region.

Funding: Medicaid, state, local, Area Agencies on Aging

Elderly-Senior Psychosocial Rehabilitation Programs

Elderly-Senior psychosocial rehabilitation is defined as a program of structured activities designed to support and enhance the ability of elderly consumers to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The objectives aim to improve skills that promote independence in daily life. Standards for the program emphasize community outreach, specialized staff training, and medical monitoring of individuals served in the program. One of the program goals, in addition to providing a daily therapeutic environment that is age-appropriate, is to establish an outreach program that focuses on locating elderly persons in the community through various means of public awareness, community meetings, and working with other local organizations.
Since FY 2001, the DMH has continued to identify and assist regions in starting elderly-senior psychosocial rehabilitation programs where appropriate populations could benefit from these services. An elderly service program application must be completed by the provider and approved by DMH prior to the program’s certification visit. This ensures that prior to an elderly program certification visit, certain elements of the program have already been reviewed and the region has a clear understanding of DMH expectations regarding services. As of April 2009, there were 58 elderly psychosocial rehabilitation programs, including 27 elderly psychosocial programs in CMHCs and 31 elderly psychosocial programs in nursing homes in CMHC Regions 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14 and 15. Given the expansion of elderly-senior psychosocial rehabilitation programs to date, focus of DMH Division of Community Services activities continue to be on monitoring local programs and providing technical assistance, both to existing and new providers of the service. Part of the FY 2004 Part of the CMHS Block Grant increase is used to support technical assistance for elderly-senior psychosocial rehabilitation programs made available through model sites operated by Region 15 Warren-Yazoo Mental Health Services and Region 12 Pinebelt Mental Healthcare Resources. A third training site was added in the nursing home in Region 6 Life Help. The training continues to be available in FY 2008. Staff employed in the programs are encouraged to attend the training prior to employment. The training is also offered to staff from other elderly-senior psychosocial programs that receive repeat deficiencies during annual site visits. Objectives of the training are to:

- Identify staff roles and responsibilities for the development, growth, and enhancement of the program
- Understand the importance and effectiveness of planning
- Establish a schedule of daily activities to meet the social, emotional, and physical needs of the participants
- Establish a list of helpful resources for securing both individual and group activities appropriate for the program participants
- Understand and identify transportation safety requirements and certifications
- Establish an environment to meet the physical, social, and emotional needs of the participants
- Identify and document effective ways to provide information about the program and outreach to the community
- Understand the delivery and effectiveness of other services, including individual, group, family therapy, case management services, and nursing services
- Understand and document all necessary data as it relates to program

As of March, 2010, the training site in Vicksburg (Region 15) had provided training to three individuals, the site in Hattiesburg (Region 12) had trained three individuals, and the elderly psychosocial nursing home training site had provided training to four individuals.

**Priority Area #8: Comprehensive Community-Based Mental Health Systems for Adults**

**Goal:** To facilitate skills training for staff of elderly psychosocial rehabilitation programs.

**Strategy:** DMH will continue to provide training for additional staff in elderly psychosocial rehabilitation programs.
**Performance Indicator:** The number of community mental health services staff who complete training for elderly psychosocial rehabilitation programs.

**Description of Collecting and Measuring Changes in Performance Indicator:** Division of Community Services monthly grant report forms

**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.

<table>
<thead>
<tr>
<th>Mental Health Transformation PI Data Table C5.3</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of training for staff in elderly psychosocial rehabilitation programs</td>
<td>Training provided for 20 staff from elderly psychosocial rehabilitation programs</td>
<td>Training for 10 staff from elderly psychosocial rehabilitation programs</td>
<td>Training for 10 staff from elderly psychosocial rehabilitation programs</td>
<td>Training for 10 staff from elderly psychosocial rehabilitation programs</td>
</tr>
</tbody>
</table>

**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
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.)

State Priority #9: Mental Health Systems Data Epidemiology for Adults with SMI

Note to Reader: Sections/objectives pertaining to prevalence estimates will be revised, pending receipt of updated information from SAMHSA.

Prevalence Estimates

Prior to the needs assessment process begun as part of the initial development of the state plan under P.L. 99-660, the state initially applied national prevalence estimates to state population data to derive a broad estimate of need for mental health services among adults. Since current federal law requires use of standardized methodologies developed by the Center for Mental Health Services for estimating incidence and prevalence of serious mental illness among adults, in this year’s (FY 2011) State Plan, Mississippi will utilize the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the (national) Center for Mental Health Services in the June 24, 1999, issue of the Federal Register. Estimates in the FY 2011 State Plan are updated from Uniform Reporting System (URS) Table 1: number of persons with serious mental illness, age 18 and older, by state, 2009, prepared by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) for the federal Center for Mental Health Services (CMHS). As noted in the estimation methodology in the Federal Register, at this time, “...technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence.” The publication also indicated that in the future, “incidence and prevalence data will be collected.”

The estimated number of adults in Mississippi, ages 18 years and above is 2,168,103 based on U.S. Census 2009 population estimates. According to the final federal methodology published by the (national) Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in Federal Register, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years old and above is 5.4 % or 117,078 in 2009. The federal methodology operationalizes the federal definition of serious mental illness among adults, published in 1992. As noted in discussion of the methodology in the Federal Register (June 24, 1999), the “12-month prevalence is estimated nationally to be 5.4 percent...” As stated in the publication, these estimates are based on noninstitutionalized individuals living in the community. Also, as pointed out in the discussion of the federal estimation methodology, “only a portion of adults with serious mental illness seek treatment in a given year (and) due to the episodic nature of serious mental illness, some persons may not require mental health services at any particular time.” The definition of serious mental illness among adults in Mississippi, described under this criterion, falls within the federal definition.

Priority Area 9: Mental Health System Data Epidemiology for Adults with SMI
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.

Strategy: DMH will utilize the revised estimated prevalence ranges of serious mental illness among adults in the FY 2012-2013 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.


Description of Collecting and Measuring Changes in Performance Indicator: 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 the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.

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 2011 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.


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 the Center for Mental Health Services, Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.
Special Issues: There are limitations to the interpretation of this prevalence estimate, explained above.

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

Funding: Federal and state funds

State-level Estimates of Prevalence of Depression and Anxiety

As described under Criterion #5 under Information Management, in FY 2005 the DMH began collaborating with the Mississippi Department of Health (DOH), which applied to and received funding from the Centers for Disease Control and Prevention (CDC) to collect state-specific information about depression and anxiety in calendar year 2006 as an additional optional data collection module, administered as part of an existing population behavioral health status survey, the Behavioral Risk Surveillance System (BRFSS). This population-based telephone survey (of adults) is administered annually by the DOH and collects data in response to core health-related questions, which is reported to the federal Centers for Disease Control (CDC). In FY 2006, the DMH also collaborated with the DOH in development of an additional funding proposal submitted by DOH to the CDC for implementation of another optional module to collect state-specific data on serious psychological distress and stigma in calendar year 2007. Data was completed during calendar year 2007. DMH applied for and received an Administrative Supplement to its Mental Health Data Infrastructure Grant (DIG) to support this collaborative work with the DOH to collect and analyze state-specific mental health prevalence estimates for adults in 2006 and 2007 and in 2010. Additionally, the Mississippi Department of Health included the depression and anxiety module in the BRFSS in 2008 and in 2010.

Quantitative Targets: Number of Individuals to be Served

<table>
<thead>
<tr>
<th>Priority Area #9: Mental Health System Data Epidemiology for Adults with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy:</strong> To make available a statewide, comprehensive system of services and supports for adults with mental illness</td>
</tr>
<tr>
<td><strong>Performance Indicator:</strong> Total number of adults with mental illness served through the public community mental health system and the state psychiatric hospitals.</td>
</tr>
<tr>
<td><strong>Description of Collecting and Measuring Changes in Performance Indicator:</strong> 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.</td>
</tr>
</tbody>
</table>
Mississippi

**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 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 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, 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 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 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 2011.

**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)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>Total persons 18+ years served in public mental health system*</td>
<td>67,611</td>
<td>62,000</td>
<td>64,775</td>
</tr>
</tbody>
</table>

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

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

**Definitions - Adults with Serious Mental Illness**

**Note:** As described in the Children’s Services Plans and in the current Mississippi Division of Medicaid Community Mental Health Manual since FY 2003, the upper age limit in the definition for children with serious emotional disturbances has been extended to up to 21 years, while the lower age limit for adults with serious mental illness has remained at 18 years. This is a difference from the federal definition for children, which defines children as being up to 18 years. The change in Mississippi’s definition has been made to allow flexibility to respond to identified strengths and needs of individuals, aged 18 to 21 years, through services in either the child or adult system, whichever is preferred by the individual and determined as needed and appropriate. This change was also made to facilitate transition of individuals from the child to
the adult system, based on their individual strengths, needs and preferences. (Totals from data in the NOM (URS Tables 2A and 2B) that follow, however, reflect only adults 18 years and above served; detailed data from URS Tables 2A and 2B indicate that 3836 youth/young adults in the 18-20 year age range were served in FY 2008). An adult with a serious mental illness is defined as any individual, age 18 or older, who meets one of the eligible diagnostic categories as determined by the DMH and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. It should be noted in the following objective that the number of adults targeted to be served includes only adults with serious mental illness served through the public community mental health system, which is a subset of the number of adults with any mental illness accessing services in the public community mental health and inpatient system, reported in the previous NOM (URS Tables 2A and 2B).

Priority Area #9: Mental Health System Data Epidemiology for Adults with SMI

**Goal:** To make available a community-based, statewide, comprehensive system of services and supports for adults with serious mental illness.

**Strategy:** Continued tracking of 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.)

**Performance Indicator:** The number of adults with serious mental illness who receive services through the public community mental health system (minimum 49,000)

**Description of Collecting and Measuring Changes in Performance Indicator:** The number of adults with serious mental illness who receive services through the public community mental health system (minimum 49,000)
Special Issues: Targets are based on trends in utilization data over time. The DMH is continuing to implement a multi-year project, with support from the CMHS Data Infrastructure Grant (DIG) Quality Improvement Project, to implement a central depository for data and to improve the integrity of data submitted from the public mental health system. As this system continues to be implemented time period, downward adjustments in targets and numbers served are anticipated, since issues of potential duplication across service providers in the current reporting system will be addressed.

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

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

Data Management: The management of adult and children’s community mental health services data, including work to establish unduplicated counts, is addressed in the data management objective described in this Plan under Criterion #5 that follows.

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

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. The Mississippi Department of Mental Health (DMH) and the Think Again Network will continue to address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services through its Think Again campaign.

In October 2009, DMH and the statewide Think Again Network launched a campaign specific to Mississippi entitled, “Think Again.” The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children’s Services and Adult Services State Plans. DMH established the Think Again Network with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign.

<table>
<thead>
<tr>
<th>PI Data Table A2.1</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td># Adults with SMI Served</td>
<td>53,910</td>
<td>49,000</td>
<td>49,000</td>
<td>49,000</td>
</tr>
</tbody>
</table>
DMH is conducting a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi’s Think Again efforts have joined forces with DMH’s Youth Suicide Prevention Campaign, “Shatter the Silence.” DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, presentations and the distribution of flyers and brochures on campus.

In October 2009, DMH and the Think Again Network launched the Think Again campaign which is an anti-stigma and mental health awareness campaign targeting young adults. Educational materials were developed for the campaign which focuses on the truths about mental illness, how to seek help, and how to fight stigma. Since Oct. 1, 2009, more than 18,000 Think Again brochures and 500 posters have been distributed. DMH worked with the Department of Education to send packets to more than 800 6th–12th grade public school nurses and counselors with a letter announcing the campaign and offering brochures, posters and presentations free of charge. As a result of the mail out, DMH received requests for more than 8,000 brochures. DMH has conducted more than 70 presentations statewide. DMH continues to combine the anti-stigma campaign efforts with the youth suicide prevention efforts. DMH conducted training in February to prepare 15 individuals to present the Think Again/Shatter the Silence presentations in their community and local schools. In October, several activities were conducted in conjunction with the campaign launch including Weems Community Mental Health Center’s Mind Matters event, Mississippi State Hospital’s Games Your Children Play Part II event, and Central Mississippi Residential Center’s Mental Health Awareness Event. Tougaloo College sent a text message to all their students announcing the campaign and offering mental health help. More than 20 television and radio interviews have been conducted and more than 70 newspaper articles have been printed reaching more than 900,000 Mississippians.

To address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services, the Mississippi Department of Mental Health (DMH) and the Think Again Network launched a mental health awareness campaign entitled Think Again. The campaign, which was launched statewide in 2009, was designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems. Because the campaign targets the transitional age range, this transformation objective was included in both the Children’s Services and Adult Services State Plans. DMH established the Think Again Network with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals, colleges, and health facilities, community mental health centers, mental health associations, hospitals, colleges, and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign, which reached an estimated 1 million individuals in FY 2010. DMH and the Think Again Network will continue to show young adults how to support their friends who are living with mental health problems. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. Combined, these campaigns teach young adults about mental health and suicide prevention. Materials and presentations for both campaigns were combined in order to present a more concise and consistent message.

<table>
<thead>
<tr>
<th>Priority Area #9: Mental Health Systems Data Epidemiology for Adults with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> 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.</td>
</tr>
</tbody>
</table>
Mississippi

**Strategy:** To provide printed materials and trainings on stigma

**Performance Indicator:** The 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

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

**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—“Think Again”

**Indicator:** To reach 200,000 individuals during FY 2011

**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.

<table>
<thead>
<tr>
<th>MH Transformation PI Data Table</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012-2013 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Individuals reached by Anti-stigma campaign</td>
<td>200,000</td>
<td>200,000</td>
<td>200,000</td>
<td>200,000</td>
</tr>
</tbody>
</table>

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

**Special Issues:** Activities to plan and kick-off the first year of the three year anti-stigma campaign began in FY 2007, therefore, the different themes will overlap the fiscal year(s) addressed in the State Plan. The anti-stigma campaign has partnered with DMH’s youth suicide prevention campaign for presentations and information distributed to young adults.
Significance: Although youth and young adults, 18-25 years of age, are almost double that of the general population, young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on. The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness.

Funding: Federal, State and/or local funds

Additional services available through the public community mental health system to prevent or decrease hospitalization and rehospitalization include mental health outreach services, case management, crisis telephone services, transitional residential programs, discharge planning and consultation/education services.

Criterion 3: Children Services (only in Children’s Plan)

Criterion 4: Targeted Services to Rural and Homeless Populations
- Describes States’ outreach to and services for individuals who are homeless
- Describes how community-based services will be provided to individuals residing in rural areas

Mental Health Transformation Activities: Services for Elderly Persons - (NRC Goal 4.4) According to the 2000 U. S. Census, approximately 16% of Mississippians are age 60 and older. Elderly persons (over 60 years old) with serious mental illness comprised approximately 6.9% of adults with serious mental illness, age 65 and above were served through the public community mental health system in FY 2009.

Annual Conference on Alzheimer’s Disease and Psychiatric Disorders in the Elderly

A DMH Division of Community Services staff will continue to serve as a conference committee member to ensure that topics pertaining to psychiatric issues affecting elderly persons are addressed at the annual conference for persons with Alzheimer’s Disease/Other Dementia.

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

Specialized Outreach and Service Programs for Individuals with Serious Mental Illness

Mississippi
who are Homeless/Potentially Homeless

The Department of Mental Health plans to continue support for specialized services targeting individuals who are homeless and have mental illness in areas of the state where there are known to be large homeless populations with a significant number of individuals with mental illness and the federal funds (Projects for Assistance in Transition from Homelessness or PATH) would have the greatest impact. The programs that are funded are located in Jackson (MS State Hospital Homeless Program) in Meridian (East MS State Hospital, Community Services Division), and on the Gulf Coast (Mental Health Association of MS, Gulf Coast Women’s Center and Singing Rivers Services). As of March, 2010, the PATH funded programs had served the following: Gulf Coast Women’s Center – 37; MSH Community Services – 78; Region 14 Singing River Services – 35; Mental Health Association of Mississippi – 115; and, EMSH Community Services – 72 for a total at mid-year of 343 people served thus far in FY 2010. These providers may change after May, 2010, as the Department of Mental Health’s Request for Proposals (RFP) for PATH is a competitive process this year. RFPs have been sent to all counties through Mississippi’s three Continua of Care – Opens Doors, Partners to End Homelessness and Mississippi United to End Homelessness. The Department of Mental Health also received notification that its application for Technical Assistance training in the SSI/SSDI Outreach, Access and Recovery (SOAR) Program offered through SAMSHA was approved. The SOAR Project helps states increase access to mainstream benefits for people who are homeless or at risk of homelessness through training, technical assistance and strategic planning.

| Priority Area #10: Targeted Services to Rural and Homeless Adults with SMI |
|---------------------------|---------------------------------------------------|
| **Goal:** To provide coordinated services for homeless persons with mental illness |
| **Strategy:** DMH will continue to provide specialized services will continue to be available for homeless individuals with mental illness in targeted areas of the state |
| **Performance Indicator:** The number of persons with serious mental illness served through specialized programs for homeless persons (833) |
| **Description of Collecting and Measuring Changes in Performance Indicator:** Adult Services State Plan Survey; PATH Grant Annual Report. |

**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
Mississippi

mental illness in targeted areas of the state

**Measure:** The number of persons with serious mental illness served through specialized programs for homeless persons (833)

<table>
<thead>
<tr>
<th>PI Data Table A4.1</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
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</tr>
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<tbody>
<tr>
<td># Served—Specialized Homeless</td>
<td>654</td>
<td>900</td>
<td>833</td>
<td>750</td>
</tr>
</tbody>
</table>

**Source(s) of Information:** Adult Services State Plan Survey; PATH Grant Annual Report.

**Special Issues:** The number served in previous years included those enrolled in the PATH program and others who had contact and were provided some assistance, but not enrolled. The results of a needs assessment changed the areas of the state targeted to continue to receive PATH funding for provision of services to individuals with serious mental illness who are homeless. Data will continue to be collected since this reconfiguration of programs.

**Significance:** Specialized outreach and services are needed to identify and address the needs of individuals who are homeless and who also have a serious mental illness, which are often unique and complex.

**Funding:** PATH (if available), local, and state funds

The DMH Division of Community Services staff member, who oversees the administration of the PATH grant program in MS, served on the Project CONNECT committee, a coalition of organizations in the Jackson-Metro area dedicated to serving persons experiencing homelessness in the Jackson area—DMH staff also continued to attend meetings of MISSIONLinks, which is an alliance of emergency and transitional shelter operators and mental health service providers, which was created in the spring of 2002 out of the need expressed by Jackson shelter operators for assistance in serving persons with mental illness who are homeless who use their facilities. Spearheaded by the MS State Hospital Community Services Stubbs Homeless Program, the alliance is comprised of about 20 local agencies, shelters, secondary treatment programs, hospitals and mental health programs. The group’s mission is “to provide avenues for information sharing, education and support among emergency/transitional shelter staff and mental health services staff, with the goal of facilitating timely and reliable linkage of mental health services for individuals with mental illness who are homeless.”

Additionally, the Division of Community Services staff member working on housing issues for individuals with serious mental illness who are not necessarily homeless, also attends meetings of the Partners to End Homelessness to facilitate coordination of planning. The Partners to End Homelessness (Partners), a group of local service providers, is a permanent partnership to coordinate services to homeless persons in the City of Jackson and Hinds County. Partners is a
community-wide effort involving nonprofit agencies, local government and other providers of services to homeless persons, housing providers, neighborhood groups and homeless or formerly homeless persons. The principal organizations involved include: Stewpot Community Services, the Salvation Army, the Veterans Administration Homeless Services, Catholic Charities, Inc., the Hinds County Human Resource Agency, Jackson-Hinds Comprehensive Health Center Homeless Clinic, the City of Jackson, the Mental Health Association of the Capital Area, Inc., the MS Department of Mental Health/PATH, the Hinds County Board of Supervisors, the Recovery Lodge, MS State Hospital Community Homeless Services, the Good Samaritan Center, Southern Christian Services/PALS, the Jackson Housing Authority, the Mississippi Regional Housing Authority No. VI, Voice of Calvary Ministries, Habitat for Humanity, Daybreak Shelter, Gateway Rescue Mission, New Hope Foundation, and Victory Community Resource, Inc. The Continuum of Care, which is completed by the Partners to End Homelessness, serves to formalize the working relationships, expand and enhance the type and quantity of services that are available for homeless persons in the local community, and provide a strategy for setting and reaching goals to help homeless persons become self-sufficient. A key aspect of the system is the completion of an annual survey among providers of services for homeless persons to help identify gaps in services.

Membership of the Mississippians United to End Homelessness Coalition is statewide and represent the Multi-County Community Action Agency in Meridian, Recovery House in Columbus, Bolivar County Community Action Program, Inc. in Cleveland, Catholic Charities (Guardian Shelter) in Natchez, the City of Natchez, the U.S. Department of HUD in Jackson, the Institute for Disability Studies at the University of Southern Mississippi in Hattiesburg and in Jackson. The goals of this group are to: serve as the lead entity in ongoing efforts to develop and implement a regional Continuum of Care plan; sponsor technical assistance workshops around the state for prospective organizations interested in applying for federal housing funds; and, facilitate and organize advocacy efforts on behalf of homeless persons, such as testimony before elected officials.

By March, 2010, DMH had participated in a Federal on-site review of the PATH program. In FY 2010, a DMH staff member also 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. The State PATH Contact, within DMH, had also conducted site visits of the five PATH programs.

**Priority Area #10: Targeted Services to Rural and Homeless Adults with SMI**

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

**Strategy:** Continued participation by A DMH staff member will continue to participate on interagency workgroups that identify and/or address the needs of individuals who are homeless.

**Performance Indicator:** The number of workgroups addressing homelessness on which DMH
Objective: To educate providers, consumers and other interested individuals/groups about the needs of homeless individuals, including the needs of homeless persons with mental illness.

Population: Adults with Serious Mental Illness

Criterion: Targeted services to rural and homeless populations

Brief Name: Gatekeeper workgroup operation and activities

Indicator: Continued participation by a DMH staff member on interagency workgroups that identify and/or address the needs of individuals who are homeless.

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

Source(s) of Information: Minutes of workgroup meetings and/or Division Activity Reports

Special Issues: The DMH staff member who works with this committee and/or other appropriate DMH staff members will also participate in additional interagency workgroups addressing homelessness (such as the Partners to End Homelessness, the MS United to End Homelessness Coalition, and MISSIONLinks), as requested. The Division of Planning will collaborate with and integrate the activities of these workgroups, which has been ongoing, as needed into a broader strategic plan for housing for persons with mental illness.

Significance: By the DMH Division of Community Services or other appropriate DMH staff participating on various interagency workgroups concerned with the needs of homeless persons, including individuals with serious mental illness, opportunities for maximizing human and fiscal resources to address those needs in a coordinated manner are enhanced. DMH staff participation in groups concerned with the needs of all homeless individuals further ensures that any specialized needs or concerns of homeless persons who also have a serious mental illness are included in the work of those groups.

Funding: State, and federal funds

Definition of areas of the state considered "rural":

In its continued efforts to assess needs and plan strategies to meet those needs in rural areas, the
Mississippi

Department of Mental Health will use the new definition of “rural,” based on revised criteria for defining urban and rural territory based on the results of the Census 2000 (Federal Register, March 15, 2002) from the Census 2000 Urban and Rural Classification, as follows:

“Territory, population and housing units located outside urban areas (UAs) and urban clusters (UCs)” are classified as “rural.” More specifically, the Census Bureau “delineates UA and UC boundaries to encompass densely settled territory, which consists of:

1. Core census groups or blocks that have a population density of at least 1000 people per square mile; and,
2. Surrounding census blocks that have an overall density of at least 500 people per square mile.

Geographic entities such as census tracts, counties, metropolitan areas and the territory outside of metropolitan areas, often are “split” between urban and rural territory, and the population and housing units they contained are partly classified as urban and partly classified as rural.”

Outreach and Provision of Services to Individuals Residing in Rural Areas

The problems of service availability and access associated with providing services in rural areas, such as transportation, are addressed through both structural and programmatic characteristics of the public community mental health system, including:

Regionalization of Community Mental Health Services

Mississippi is divided into 15 multi-county regions for the planning and implementation of community mental health services. Community mental health services are provided through comprehensive centers located in each region.

County Mental Health Services/Offices

The comprehensive regional community mental health centers maintain services in each county of the service region to improve accessibility of community mental health services.

Mobile Medication Evaluation/Monitoring

Appropriate staff from comprehensive community mental health centers make trips throughout the regions for monthly medication checks for center clients receiving medication through the community mental health center. The 15 CMHCs will continue to make available medication evaluation/monitoring services to individuals with serious mental illness living in all counties, including those that are rural.

Transportation

Community mental health centers will continue to be required to develop plans for outreach, including transportation, as part of their community support services plans approved by the Department of Mental Health. In FY, 2009, 15 CMHCs, the Community Services Divisions of
EMSH and MSH, and CMRC reported utilizing center operated van/other vehicles; 10 CMHCs reported making transportation affiliations agreements with other agencies; and 11 CMHCs, the Community Services Divisions of EMSH and MSH and CMRC reported utilizing local public transportation (buses, cabs, etc.) and Medicaid transportation.

**Priority Area #10: Targeted Services to Rural and Homeless Adults with SMI**

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

**Strategy:** Availability of plans by community mental health centers for outreach, including transportation services.

**Performance Indicator:** The number of CMHCs that have available local plans that address transportation services (minimum, 15)

**Description of Collecting and Measuring Changes in Performance Indicator:** Community support services plan reviews.

**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)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Local Plans Addressing</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>15 CMHCs</td>
<td>15 CMHCs</td>
<td>15 CMHCs</td>
<td>15 CMHCs</td>
</tr>
</tbody>
</table>

**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
Mississippi

services that are available in their communities and/or region.

Funding: Local, Section 18 contracts, Section 16b2 purchasing, SSBG, state, and local funds

Mississippi Statewide Coordinated Transportation System Project

In FY 2008, the DMH Division of Community Services continued implementation of a Rebalancing Initiative, the Mississippi Statewide Coordinated Transportation System project, which was funded through a Real Choice Systems Change Grant that ended on September 30, 2008. The purpose of this planning grant was to develop a design and implementation plan for a statewide coordinated transportation system that will allow Mississippians with disabilities to access community-based long-term supports anywhere in the State, thereby enabling them to 1) live in the most integrated community setting appropriate to their individual support requirements and preferences; 2) exercise meaningful choices about their environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and 3) obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

The no-cost extension period of the project included the project’s final year from October 1, 2007 through September 30, 2008. The major activities of the project during this period included the following: (1) The Mississippi Transportation Coalition, which includes approximately 40 member organizations and serves as the advisory group to the Mississippi Coordinated Transportation System project, continued to meet monthly to develop a plan for coordinated transportation services in Mississippi. (2) The Coast Transportation Coalition, a subgroup of the Mississippi Transportation Coalition, continued to meet. This group was organized to ensure that the plan for coordinated transportation services developed by the Mississippi Transportation Coalition addresses the service needs of citizens in Hancock County, which was especially hard hit by the effects of Hurricane Katrina. (3) The Coalition developed a general description of a coordinated transportation system for the State, providing an overview of how the system should be organized and the roles of the primary stakeholders. (4) Components of the coordinated transportation system were implemented and tested through the Solutions for Individualized Transportation (SIT) project for their effectiveness and recommended inclusion in the final plan for the coordinated transportation system. This project is funded by the Mississippi Council on Developmental Disabilities and managed by The Arc of Mississippi. (5) Staff of the Mississippi Coordinated Transportation System project wrote a grant, which was funded by the Mississippi Council on Developmental Disabilities, to develop specifications and identify possible funding sources for a transportation call center, to be developed in Vicksburg. The Mississippi Transportation Coalition, which includes representation from the DMH, continues to meet monthly to address coordinated planning for transportation. In FY 2010, the DMH received Transformation Transfer Initiative (TTI) funding from the Center for Mental Health Services, one component of which will enhance the coordination of transportation services and service providers. DMH will also utilize grant funds to pay for transportation for individuals with disabilities. In FY 2011, DMH continues to work on a pilot project in the Region 6 CMHC catchment area. It is anticipated, that after 100 transportation needs assessments have been conducted, a local transportation provider will begin a call in center. This call in center will provide rides to individuals with disabilities at
a reduced rate. It is our hope to replicate this pilot project statewide when funding is available.

(To be updated and moved to Section I)

The Telepsychiatry Project (described under Criterion #5 that follows), which is being implemented by the University of Mississippi Medical Center, Department of Psychiatry and Human Behavior with a grant from the Delta Health Alliance, is facilitating the provision of psychiatric services in two CMHC regions in the Delta (Regions 1 and 6), and expanded to some satellite sites in FY 2010. They have expanded this service across other counties in the Delta and expect to have all community mental health centers in that region connected by the fall of 2010. The project also is designed to provide training to front line providers at the community mental health centers in the latest evidence-based interventions (e.g., motivational interviewing). All crisis stabilization units are equipped for tele-health.

Minimum services typically available through satellite offices/services include outpatient, medication evaluation, pre-evaluation screening, and/or case management.

Satellite offices or services of regional CMHCs located in 95% of the counties in MS that are designated as rural will continue to make available mental health services to rural areas of the state.

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 2011

State Priority #11: Management Systems for Adults with SMI

The Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center (UMMC) has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Additionally, a rotation in outpatient substance abuse
Mississippi

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 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 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

Pre-evaluation screening is a step in the civil commitment process, required by state law to be conducted by the CMHCs. Descriptive information from the screening is provided to the court to determine whether or not it is appropriate to proceed with the commitment examination, which by statute, is conducted by either two licensed physicians or a licensed physician and a licensed psychologist, nurse practitioner or physician assistant certified to conduct commitment examinations. This pre-evaluation screening is a component of the process for inpatient and outpatient civil commitments. The DMH requires that all CMHC staff who conduct pre-evaluation screening successfully complete specialized training for certification in this area.

As of March, 2010, two pre-evaluation training sessions, in which 45 individuals were trained, had been held. Two consumers shared their perspectives of going through the pre-evaluation screening process with CMHC staff in the training. HB 1525, which made changes to the civil commitment statutes, was passed during the 2010 Legislative session. Major changes resulting from that legislation included specification and caps on costs of filing of affidavits and on assessment of other fees supporting the civil commitment procedures and other requirements and clarifications designed to streamline and standardize the process across counties and to facilitate access to emergency care. These changes were incorporated into the pre-evaluation training sessions in FY 2010.

Priority Area #11: Management Systems for Adults with SMI

Goal: To continue to provide training on pre-evaluation screening for individuals being considered for civil commitment will be made available.

Strategy: DMH will continue to make available training sessions in pre-evaluation screening to CMHC staff who meet the minimum criteria for providing this service, in accordance with DMH Minimum Standards Operational Standards
**Performance Indicator:** The number of training sessions in pre-evaluation screening made available by DMH (minimum of four).

**Description of Collecting and Measuring Changes in Performance Indicator:** DMH data

**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).

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<tbody>
<tr>
<td># Pre-evaluation Screening Training Sessions</td>
<td>6; 95 trained</td>
<td>4</td>
<td>4</td>
<td>4</td>
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</tbody>
</table>

**Source(s) of Information:** DMH Training Records

**Special Issues:** None

**Significance:** The pre-evaluation training is designed to increase uniformity in procedure and to better ensure minimum competence level of staff who conduct screening. This training should enhance the information provided to the court and facilitate communication between mental health providers, consumers and families, and the court system.

**Funding:** State funds

**Training of Emergency Health Workers in the Area of Mental Health**

**Mental Health Transformation Activity:** Improving Coordination of Care among Multiple Systems
Training of Law Enforcement Involved in Emergency Situations

Through planning aimed at improving community-based crisis and emergency services, the need for training of law enforcement was identified as a major need and included in the State Plan. Frequently, law enforcement officers may be among the first emergency personnel on the scene who interact with consumers and families in crisis, and they might also be involved in the civil commitment process. The DMH has an agreement with the MS Department of Public Safety to provide professional mental health staff from the CMHCs to provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. As a result, a curriculum was developed and implemented in 1997 for recruits being trained through the six state law enforcement academies. This curriculum was developed by the Law Enforcement Task Force, made up of family members, consumers, mental health providers and Department of Public Safety representatives. To also address the training needs of experienced law enforcement officers, the Law Enforcement Task Force developed a curriculum for in-service training, through which law enforcement officers currently in the field can receive continuing education credit, which was implemented in 1998. DMH certified trainers from throughout the state have continued to conduct either the recruit or in-service training. Additionally, in the Warden at the Harrison County jail made a video on the importance of communication between law enforcement and community mental health staff. The video’s message urges law enforcement professionals to take advantage of law enforcement training provided by community mental health center staff.

In FY 2008 – FY 2010, DMH made funding available to 15 CMHCs to help support provision of law enforcement training. As of March 2010, CMHCs reported 13 sessions had been conducted, with 165 law enforcement officers trained. As noted under Criterion 1, because of budget restrictions, DMH will not continue funding to support the provision of law enforcement training by the CMHCs in FY 2011, but will continue other efforts to network with law enforcement and/or emergency services entities, and mental health providers explore other avenues 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.

For example, the DMH is supportive of efforts by the City of Hattiesburg to plan and implement a Behavioral Health Court in Forrest and Perry counties, supported through funding from the federal Bureau of Justice Administration. In FY 2010, the Lauderdale County Sheriff’s Department, in collaboration with NAMI-MS, Weems Mental Health Center and a community-based mental health partnership in their community, also applied for a Justice and Mental Health Collaboration Program grant. If funded, the grant will support planning, and potentially, implementation of activities involving screening at booking, pre-release and post-release services, the provision of some mental health services (including aftercare and transition planning), as well as the provision of cross-training of staff working in the criminal justice and mental health systems.

In December 2008, DMH staff addressed the Mississippi Chiefs of Police Conference and the Mississippi Sheriff’s Association Conference. DMH staff also addressed the Mississippi Sheriffs’ Association in FY 2010. These presentations communicated DMH’s desire to collaborate with law enforcement offices to provide education and support services for officers intervening with
Mississippi

citizens experiencing mental illness crises.

The DMH reconvened the Law Enforcement Task Force that initially developed the training modules for law enforcement (described above), with the intent to revise the training, if needed, for use with other types of emergency/health personnel. The Law Enforcement Task Force reviewed the Department of Mental Health Minimum Operational Standards that require local community mental health service providers to have agreements with local hospitals to train non-mental health emergency personnel. Compliance with this standard will continue to be reviewed as part of regular certification site visits by DMH. DMH staff continued to monitor implementation of a standard requiring CMHCs to maintain agreements to provide training to local hospitals, as requested. In FY 2008, DMH began collaboration with the Hinds County Sheriff’s Department and the Jackson Police Department to establish a CIT program in the Hinds/Jackson area. A Hinds/Jackson CIT Task Force was established in August 2008. In November, 2008, members of that task force participated in a three-day training visit with the Memphis Police Department CIT through the University of Memphis. Legislation to establish the Hinds/Jackson CIT (H.B. 897) was proposed to the Legislature, but provisions pertaining to CIT in the bill did not pass in 2009. In 2010, HB 1049 was passed during the Regular Legislative Session and provides the framework needed for the establishment of Crisis Intervention Teams (CIT) by local jurisdictions statewide; no additional appropriations specifically for that purpose were authorized by the bill. In FY 2011, DMH will continue collaboration with community mental health centers and law enforcement to develop CIT programs.

(To be updated)

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<tr>
<th>Financial Resources</th>
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<td>Federal Grants (CMHS, SSBG, SAPT, PATH)</td>
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<tr>
<td>State Funds (grants, Medicaid match)</td>
<td>15,806,402</td>
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<tr>
<td>Healthcare funds (grants, Medicaid match)</td>
<td>2,871,990</td>
<td>2,871,990</td>
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<tr>
<td>Trf. from CMHCs for Medicaid match</td>
<td>4,665,100</td>
<td>4,665,100</td>
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<tr>
<td>Special Funds (EMSH/MSH)</td>
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<tr>
<td>Crisis Center funding (total funding)</td>
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<td>Local Taxes*</td>
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<td>Federal Medicaid Reimbursements*</td>
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<td>Total</td>
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*Based on estimated use of funds for adult services of 55% of total local taxes and Medicaid funds for community mental health services provided by CMHCs.

Note: The following section is deleted here, but is addressed in a section that combines objectives that pertain to both children’s and adults’ services.

**Efforts to Increase Funding**

Mississippi’s budget process is such that funds the Department of Mental Health requested in the 2010 legislative session, which began in January of 2010, would be made available for the fiscal year that begins July 1, 2010, and ends June 30, 2011. In its initial budget request for FYE 6/30/2011, the Department of Mental Health requested an increase of $56,030,731 (an increase of about 25½%). This requested increase was for all services provided through the Department (mental health services for adults and children, services to persons with substance abuse diagnoses, services to persons with intellectual and developmental disabilities, and services to persons with Alzheimer’s disease and other dementia; inpatient and outpatient services in all areas). Included in that requested increase, which totaled $45 million, were (1) funding to replace loss of enhanced Federal share of Medicaid under the American Recovery and Reinvestment Act (about $13 million); (2) additional funding to fully fund Medicaid match for the CMHC program (about $30 million) and (3) funding to replace a reduction in grant funding (about $2 million). None of the requested increase was awarded. Additionally, the original general fund appropriation for FYE 6/30/10 (approximately $220,500,000) was cut to about $200,000,000 during the fiscal year due to declining tax revenues. This cut was taken entirely from residential and institutional based services. The financial situation for the next fiscal year (FYE 6/30/12) does not really appear any better. DMH will be addressing funding for that fiscal year during the legislative session that will begin in early January 2011.

| Goal: To increase funds available for community services for children with serious emotional disturbance and adults with serious mental illness— |
| Strategy: The Department of Mental Health will seek additional funds in its FY 2013 budget request for community support services for children with serious emotional disturbances and adults with serious mental illness. |
| Performance Indicator: Inclusion of request for increased state funds to support community mental health services for children in the FY 2013 DMH Budget Request. |
| Description of Collecting and Measuring Changes in Performance Indicator: DMH Budget Request, FY 2012 |

**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 2012 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 2012 DMH Budget Request.

Source(s) of Information: DMH Budget Request, FY 2012

Special Issues: Based on the most recent estimated use of funds of 55% for adult services of the total to be requested for adults’ and children’s community mental health services, this percentage is currently reflected in the projection for additional state matching funds for adult mental health services provided by CMHCs and funded through Medicaid (in preceding projected budget request).

Significance: Increased availability of state funding for community mental health services will positively impact the rate of expansion of the services for which any increase is received.

Funding: State

Staffing - Human Resources, CMHCs:

<table>
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<tr>
<th>POSITION</th>
<th>Total Staff</th>
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<tbody>
<tr>
<td>1. Psychiatrists</td>
<td>35</td>
</tr>
<tr>
<td>2. Other Physicians</td>
<td>9</td>
</tr>
<tr>
<td>3. Psychologists, Ph.D.</td>
<td>13</td>
</tr>
<tr>
<td>4. Staff with Master’s Degree or Above in Field of Psychology</td>
<td>89</td>
</tr>
<tr>
<td>5. Other Psychologists</td>
<td>18</td>
</tr>
<tr>
<td>6. Social Worker (MSW, Other Master Degree or Above)</td>
<td>250</td>
</tr>
<tr>
<td>7. Other Social Workers</td>
<td>87</td>
</tr>
</tbody>
</table>

61
Funding for Services for Persons with Co-occurring Disorders

In FY 2009 DMH allocated $1,154,132 from Substance Abuse Prevention and Treatment (SAPT) Block Grant funding to the 15 CMHCs for services to individuals with co-occurring disorders of mental illness and substance abuse; of this amount, $37,000 was allocated to provide training to all 15 CMHCs. Additional training addressing co-occurring disorders was provided at the 2nd Annual Mississippi School for Addiction Professionals. MSH Division of Community Services was also allocated funding to continue operation of a community-based residential treatment program for individuals with a dual diagnosis. Funding for services to individuals with co-occurring disorders of mental illness and substance abuse will continue in FY 2011, and as described previously, training on integrated assessment and treatment for co-occurring disorders will continue to be implemented with support from the Transformation Transfer Initiative funded by CMHS.

Mental Health Therapist Certification and Licensure Program

The Mental Health Therapist Professional credentialing program began on July 1, 1997 as a result of 1996 Mississippi Legislative action. It is a voluntary program designed for Master’s level or above mental health staff members who are employed within Mississippi’s state mental health system and who do not hold another mental health professional credential. Individuals enter the program at the level of Provisional Certification and are required to prepare for and pass a Mental Health Therapist written exam before advancing to either full Certification or Licensure. The content of the Mental Health Therapist Exam and corresponding study guide was outlined by a steering committee made up of community mental health service providers, consumer advocates, consumer/family members and administrators. Once an individual holds either full Certification or Licensure, he/she is required to obtain at least 30 continuing education (CE) hours of mental health-related training over a two-year period in order to meet biennial renewal requirements. (*Note: the Mental Health Therapist licensure level is no longer available to new individuals, effective January 2009; however, individuals who achieved this level prior to its discontinuance are able to maintain it as long as they continue to meet the renewal requirements.)
Licensed Department of Mental Health (DMH) Administrator Program

The Mental Health Administrators program began on January 1, 1998, as a result of 1997 Mississippi Legislative action. Mental Health Administrator licensure is a voluntary program designed for Master’s level or above individuals who hold positions as the top-level administrator or who demonstrate the potential for future advancement into positions as top-level administrators. Following admission to the program, a successful applicant is considered to be a Program Participant. Once an individual enters the Program as a Program Participant, he/she must complete a program of Independent Study/Training to obtain licensure. Two Independent Study/Training Options are currently available: Option One—successful completion of the Mississippi Certified Public Manager program and a series of written examinations based on Mississippi rules/regulations/standards and Option Two—successful completion of the Mississippi Certified Public Manager program and completion of the Department of Mental Health’s leadership development program, Focus. After one of these Independent Study/Training options has been met, Program Participants are issued licensure. Once licensed, each individual is expected to accrue at least 40 contact hours of continuing education for biennial renewal.

Case Manager Certification Program

The Case Manager Certification Professional credentialing program began on July 1, 2005, as a result of 1996 Mississippi Legislative action. It is a voluntary program, which was designed for Bachelor’s level or above individuals who provide or supervise case management services to individuals within the state mental health system. Individuals enter the program at the level of Provisional Certification and are required to attend Case Management Orientation and pass the associated written exam before advancing to full Certification. Once fully certified, each individual is expected to accrue at least 24 contact hours of continuing education for biennial renewal.

In FY 2009, PLACE staff underwent a review of its procedures and credentialing requirements. The state of the economy and fuel costs, the need for more flexibility for community mental health providers, as well as the financial and human resource needs of the Department of Mental Health were all factors in this review. As a result, PLACE made a number of changes:

- Began conversion of credentialing information and application forms to a web-based and/or email format. Therefore, PLACE staff no longer track how many application booklets are mailed out.
- Converted the previously required three Mental Health workshops and exams into one standardized exam which is now administered in a self-study format. PLACE provided training materials to programs statewide. PLACE provided study materials to applicable programs.
- Changed the Independent Study/Training component for the Licensed DMH Administrator program to offer two options for Program Participants. Within the “exam option,” the requirement was changed from six written exams to three. Of the available written exams, Program Participants are allowed to select the three exams from regulation topics that interest them most.
- Changed the training requirement for the Case Management program from three...
workshops to one, focused training experience and written exam. Case Management Orientation is the sole training and exam requirement for an individual to advance from provisional certification to full certification.

- Discontinued requiring CEs to move from provisional to full certification or licensure. CEs are only required to renew.

The number of individuals holding professional certification or licensure within the Mental Health Therapist Program, the Licensed DMH Administrator Program and the Case Management Certification Program will be maintained by PLACE staff. Because individuals holding these credentials will be required to report continuing education hours when applying for credential renewal, the number of individuals holding these credentials will be considered an indication of the number of individuals in the process of pursuing ongoing in-service/training.

Objective: To continue to implement the voluntary Mental Health Therapist certification/licensure program, the Licensed DMH Administrator and Case Management Credentialing 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 Licensed DMH Administrator program will be maintained by PLACE staff; the number of individuals who hold a credential in the Case Management Professional Program will be maintained by PLACE staff.

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 Licensed DMH Administrator program; the number of individuals who hold a credential in the Case Management Professional program. (Note: This measure includes individuals whose credentials have lapsed/expired.)

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

Special Issues: None

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

The number of individuals who hold a credential in the Mental Health Therapist program, the number of individuals who are participants in the Licensed DMH Administrator program, and, the number of individuals who hold a credential in the Case Management Professional Program projected for FY 2011 are indicated in the chart that follows:

<table>
<thead>
<tr>
<th>Credentialing Program</th>
<th>FY 2009 (Target/Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Actual)</th>
<th>FY 2012 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Therapists (all levels)</td>
<td>1,973/2,161</td>
<td>2,175</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Administrators (all levels)</td>
<td>122/126</td>
<td>125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals in the Case Management Certification Program (Beginning FY 2006)</td>
<td>607</td>
<td>845</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals who hold a credential in the Mental Health Therapist Program</td>
<td></td>
<td></td>
<td>1,275</td>
<td></td>
</tr>
<tr>
<td>Number of individuals who are participants or who hold a credential in the Licensed DMH Administrator Program</td>
<td></td>
<td></td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Number of individuals who hold a credential in the Case Management Professional Program</td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

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

**Note:** The following sections are under review/will be updated.

Academic Linkages at the Local Level continued in FY FY 2009, 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.

Note: Additional objectives on training in cultural diversity, family education/support, consumer education/support, and psychosocial rehabilitation programs are described under Criterion 1.

Note to Reader: The following section is deleted here, but is addressed in a section that combines objectives that pertain to both children’s and adults’ services.

Information Management Systems Development

The Department of Mental Health will continue ongoing efforts to implement a more standardized system of computerized data collection, including data needed for reporting on the National Outcome Measures (NOMS) and data needed for reporting in the Uniform Reporting System tables requested by the federal Center for Mental Health Services (CMHS). The national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the DMH has applied for and received three Mental Health Data Infrastructure Grants (MH-DIG) from the CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.

As mentioned, the DMH has used the DIG funds to support design, refinement and implementation of reporting systems that will facilitate community service providers’ and state psychiatric hospitals’ submission of data contained in the URS tables. DMH submitted the following URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16 (some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, the DMH has continued to use DIG funds to...
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support collection and reporting of consumer satisfaction survey information for adults and families of youth served by the public community mental health system. Consumer satisfaction survey information is also being collected to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2010, efforts continued to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan-related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers’ local systems have been problematic in state level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH-DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined information that is detailed to the client level from all DMH certified and funded providers. As a result, the DMH now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children’s services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser-based system for data entry from these organizations.

The DMH Division of Information Systems and Division of Planning staff will continue to participate in CMHS conference calls and national meetings, held regularly to discuss the development of the URS data tables. DMH staff also will communicate regularly with the community mental health centers’/other providers’ data managers as progress on development of the URS data tables continues. DMH Division of Information Systems and Division of Planning staff will also continue work with programmatic staff at the state level in the Bureau of Mental Health and at the local provider level to coordinate development of state plan reporting, including National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2008–FY 2010), which will enable the Mississippi Department of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts for the Uniform Reporting System measures, including the National Outcome Measures as
required for the CMHS Block Grant program, to identify trends in services and outcomes, and increase the involvement of stakeholders in planning. The goals of the proposed project are to:

1. Refine the central data repository for public mental health system data;
2. Refine the process for collection and reporting of information from consumer and family satisfaction surveys;
3. Improve data quality assurance systems; and
4. Increase accessibility and use of URS/NOMs measures and other mental health system data by the Mississippi State Mental Health Planning Council, DMH staff and other stakeholders involved in planning and system improvement activities.

If its application for another three years of funding for the data infrastructure project is approved, DMH will pursue project plans to refine and implement a strategic plan for reporting client level data for the National Outcome Measures targeted by CMHS, for refining infrastructure and processes for data collection and reporting, as well as for improving data integrity. Through continued data infrastructure development, quality assurance and technical assistance activities described in this proposal, the integrity and completeness of timely, detailed data to support measures for the Uniform Reporting System (URS) tables, including the National Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well as integration of the measures with other quality assurance information, will facilitate state planning and performance improvements across the system of services and supports for individuals with mental illness and their families.

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

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

**Population:** Adults with Serious Mental Illness

**Criterion:** Management Systems

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

**Indicators/Strategies:**

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

1. 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 MH DIG Quality Improvement project;
2. Periodic review and Revision of the DMH Manual of Uniform Data Standards;
3. 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
Mississippi

assistance/training needs. Activities may include, but not be limited to:

• Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs;
• Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the MH DIG Quality Improvement project, if funded;
• Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Measure: Progress on tasks specified in the Indicator.

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

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

Funding: State funds, Federal funds

<table>
<thead>
<tr>
<th>Projected FY 2011 2012-2013 CMHS Block Grant Projected Expenditures by Type of Service for Adults with Serious Mental Illness</th>
<th>Projected Est. Expend.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>$353,761</td>
</tr>
<tr>
<td>Medication Evaluation/Monitoring</td>
<td>$79,523</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>$3,804</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>$26,283</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation/Employment Enhancement</td>
<td>$616,799.48</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$43,340</td>
</tr>
<tr>
<td>IM/SC Administration of Psychotropic Medication</td>
<td>$1,558</td>
</tr>
</tbody>
</table>
Mississippi

Case Management / ICM $741,829
Emergency $34,264
Community Residential $34,822
Consumer and Family Education/Support $127,006
Peer Review/Technical Assistance $32,376.52
Drop-in Center $69,660
Adult Making A Plan (AMAP) Teams $29,315
Transportation pilot program $10,870

TOTAL $2,205,211

Projected Allocation of FY 2014 2012-2013 CMHS Block Grant Funds for Adult Services by Region/Provider

Provider Projected Allocation

Region One Mental Health Center $99,167.14
P.O. Box 1046
Clarksdale, MS 38614
Karen Corley
Interim Executive Director

Communicare $126,368.13
152 Highway 7 South
Oxford, MS 38655
Carole B. Haney, Acting Executive Director

Region III Mental Health Center $114,425.14
2434 S. Eason Boulevard
Tupelo, MS 38801
Robert J. Smith, Executive Director

Timber Hills Mental Health Services $131,843.14*
P.O. Box 839
Corinth, MS 38834
Mississippi

Charlie D. Spearman, Sr., Executive Director

Delta Community Mental Health Services  $121,818.00*
P.O. Box 5365
Greenville, MS 38704-5365
Richard Duggin
Executive Director

Life Help  $146,453.00*
P.O. Box 1505
Greenwood, MS 38930
Madolyn Smith, Executive Director

Community Counseling Services  $130,475.00*
P.O. Box 1188
Starkville, MS 39759
Jackie Edwards, Executive Director

Region 8 Mental Health Services  $134,349.00*
P.O. Box 88
Brandon, MS 39043
Dave Van, Executive Director

Hinds Behavioral Health Services  $140,758.13
P.O. Box 7777
Jackson, MS 39284
Margaret L. Harris, Director

Weems Community Mental Health Center  $138,304.13
P.O. Box 4378
Meridian, MS 39304
Maurice Kahlmus, Executive Director

Southwest Mississippi Mental Health Complex  $134,603.13
P.O. Box 768
McComb, MS 39649
Steve Ellis, Ph.D. Executive Director

Pine Belt Mental Healthcare Resources  $150,979.13
P.O. Box 1030
Hattiesburg, MS 39401
Jerry Mayo, Executive Director

Gulf Coast Mental Health Center  $136,553.13
1600 Broad Avenue
Gulfport, MS 39501-3603
Jeffrey L. Bennett, Executive Director
Mississippi

Singing River Services  $101,484.14*
3407 Shamrock Court
Gautier, MS 39553
Sherman Blackwell III, Executive Director

Warren-Yazoo Mental Health Services  $92,885.14
P.O. Box 820691
Vicksburg, MS 39182
Steve Roark, Executive Director

NAMI-MS  $67,802.00
411 Briarwood Drive - Suite 401
Jackson, MS 39206
Tonya Tate, Executive Director

Mental Health Association of Mississippi  $66,691.00
P.O. Box 7329
4803 Harrison Circle
Gulfport, MS 39507
Kay Denault, Executive Director

MS Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
Edwin C. LeGrand III, Executive Director

Funds to support consumer and family education/training opportunities at annual state conference, as well as other local, state or national education/training opportunities  $127,006.00

Funds to support enhancement of employment opportunities  Amt. included in awards for Region 5

Funds to support peer monitoring  $32,376.52*
(Funds listed under DMH may be granted to local entities for implementation)

Funds to support pilot transportation project  $10,870

Total  $2,205,211
Mississippi

*Corrected reporting errors as reflected in modification to FY 2010 Plan.

Note: A total of $187,722 (5% of the total award to be spent on services in FY 2011) will 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.

Table C. Mental Health Block Grant Funding for Transformation Activities

<table>
<thead>
<tr>
<th>Transformation Activity</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1: Americans understand that mental health is essential to overall health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 2: Mental health care is consumer and family driven.</td>
<td>X</td>
<td>$264,468</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 3: Disparities in mental health services are eliminated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 4: Early mental health screening, assessment, and referral to services are common practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 5: Excellent mental health care is delivered and programs are evaluated.</td>
<td>X</td>
<td>$32,376.52</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 6: Technology is used to access mental health care and information.</td>
<td></td>
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</tr>
</tbody>
</table>

A wide range of activities are included in Mississippi’s overall transformation agenda. The contributions by and partnerships with mental health consumers, family members and various service providers are essential to the transformation of the public mental health services and system.

Goal II: Mental health care is consumer and family driven. The DMH Division of Consumer and Family Affairs (DCFA) plans to use MHBG funds to support a number of consumer and family focused programs in FY 2011 as was done in FY 2010. Funds will be designated to continue promoting meaningful involvement of consumers and family members in the DMH’s move toward a recovery and outcomes-oriented system. The DCFA has been charged with taking the lead in guiding initiatives that promote principles of recovery in system transformation efforts. Specifically, funds support the National Alliance on Mental Illness-Mississippi chapter (NAMI-MS) to provide training, family education and support activities through their Family to Family curriculum. NAMI will spend time developing an ideal NAMI
system model for the State and will seek grant, foundation, and other funding resources. Plans are to focus on developing partnerships with primary health care providers, community mental health providers and others in coordinating direct service, education, and support ($87,602). MHBG funds will also be used to support a drop-in center for consumers in the southern part of the State ($69,660). Finally, funds will be used for networking with current consumer/advocacy groups for potential membership on advisory councils, and distribution of educational materials to service providers about trainings offered through the Leadership Academy and Recovery Now ($127,006).

**Goal V:** Excellent mental health care is delivered and programs are evaluated. Improving the functioning of adults and transition age young adults with serious mental illness receiving services (from their prospective) is a key indicator in assessing progress on other goals designed to improve the quality of services and support recovery-oriented systems change. The Division of Community Services supports the activities of one full-time and two part-time peer specialists, which include conducting on-site peer reviews and monitoring of community based mental health services. 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. Additionally, a Recovery Self-Assessment tool was developed to measure the DMH transformation from a traditional mental health service system to a recovery-oriented system of care. One goal of the assessment is to assist stakeholders and service providers to consistently track transformation activities in accordance with the DMH’s vision of developing a person-driven, recovery-oriented system of care.

The Bureau of Community Services and the DCFA will continue to explore areas to train and employ Peer Specialists and educate the community mental health systems on their role in the recovery process. It is the intent of the Division to move the mental health system to a wellness model that empowers consumers to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process ($32,376).

**Note:** Activities addressing other Transformation Goals (e.g., a statewide anti-stigma campaign, Goal I; planning and training in cultural competence, Goal III; planning and training in providing integrated services for persons with co-occurring disorders, Goal IV; and, telehealth initiatives to provide psychiatric services/consultation and training, Goal VI) are supported through other federal and/or state funds.

**Objectives, Strategies and Performance Indicators for Children with serious emotional disturbance (SED) and Adults with serious mental illness (SMI)**

**Mental Health Transformation Activities:** Workforce Development and Involving Consumers Fully in Orienting the Mental Health System Toward Recovery (NFC Goal 2.2)
Training of Mental Health Service Providers

The Department of Mental Health has continued to make available case management orientation training for staff hired as case managers in the public community mental health system. As of March 2010, DMH had conducted/facilitated four case management orientation sessions, and 113 case managers had been trained. As noted previously, DMH is drafting updated Rules and Regulations for the Case Management Certification Program and intends to pilot an online self-study feature for the Case Management Credentialing Program, which will eliminate the need for the current case management orientation program and the corresponding objective. Providing the case management training program online will provide cost savings to the state, as well as to service providers, through decreases in staff time and overnight to attend training in the Jackson area. These will be the final two case management orientation sessions. A total of 54 case managers completed the orientation. In 2011 The Mississippi Department of Mental Health (DMH) announced the implementation of a new Internet-based staff training and development program - Elevate powered by Essential Learning. It is a customized training website for the Department of Mental Health that presents and tracks staff training requirements in an accessible and easy to use format. The Essential Learning training website will take the place of case management orientation and eliminate the need for extensive travel for case management credentialing.

Implementation of Consumer Information and Grievance Reporting System

The Office of Constituency Services was established by the Department of Mental Health in response to a provision in the Mental Health Reform Act. The major responsibilities of this office include establishing and maintaining a 24 hour toll-free help line for responding to needs for information by consumers and their family members and other callers to the help line. This office is also responsible for responding and attempting to resolve consumer complaints about services operated and/or certified by the Department of Mental Health. Policies and procedures have been developed for resolving consumer complaints, both formally and informally. This office also maintains a computerized database of all DMH-certified services for persons with mental illness, mental retardation and substance abuse and continues to add other human services resources, as caller needs require. Information is accessible to all callers through staff via a toll-free telephone number. The number is accessible 24 hours a day, seven days a week. OCS is also contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in MS. The federally funded NSPL routes callers from MS to OCS for crisis intervention, suicide prevention, and resource referrals according to established policies and procedures. Through mid-FY 2010, OCS has received 6497 calls on the Suicide Prevention Lifeline. Data from these calls are included in the quarterly reports. This affiliation allows OCS access to real time call trace on all crisis calls and tele-interpreter services for all non-English speaking callers. OCS is also contracted with NSPL to give population specific referrals to individuals that identify themselves as a veteran. The DMH Minimum Standards for Community Mental Health/Mental Retardation Services - Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers address services provided by OCS, including: (1) accessing the help line for information, referrals and complaints; (2) reporting serious incidents to DMH; and, (3) the availability of local grievance procedures, as well as procedures for grievances through OCS.
OCS staff participates in certification visits to each program to monitor compliance with standards related to grievances/complaints and to follow up on previous complaints. This Office also continues to process and attempt to resolve consumer complaints through formal and informal procedures and track calls to develop reports for DMH management staff. Reports about the nature and frequency of calls to the help line (deleting all confidential information) are distributed quarterly to the DMH Executive Director, Bureau Directors and the OCS Advisory Council. Reports indicate the number of referrals, calls for information and investigations of different levels of complaints by provider. OCS has developed training modules on serious incident reporting, handling crisis and suicide calls, and any applicable minimum operational standards monitored by OCS. These modules are available as requested by any DMH-certified program.

In FY 2010, OCS continued to meet biannually with an advisory council formed in FY 1999, which includes family, consumer and service provider representatives of all major service areas administered by DMH (mental health, substance abuse, and mental retardation/developmental disabilities). Additionally, OCS continues to publish, distribute, and update the “Directory on Disk” program to all DMH facilities and community mental health centers, as well as DMH Central Office staff. This directory gives service providers access to basic program/service information for over 2700 programs and support groups statewide. This distribution and training remain ongoing. Work has continued on upgrading the computerized system so that new versions of directory on disk will be disseminated. In addition, future updates for programs in the system will be obtained via computer, rather than on paper. OCS continues to update the statewide database used for information and referral (approximately 45 new programs were added and over 344 individual programs’ information has been updated in FY 2010); this process is also ongoing.

<table>
<thead>
<tr>
<th>Goal: 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.</th>
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<tbody>
<tr>
<td>Strategy: 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.</td>
</tr>
<tr>
<td>Performance Indicator: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports).</td>
</tr>
<tr>
<td>Description of Collecting and Measuring Changes in Performance Indicator: Data provided through the software, as calls to the OCS help line logged into the computer system.</td>
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</table>

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

Population: Children with serious emotional disturbances

Criterion: Comprehensive, community-based mental health system.
Brief Name: Constituency Services Call Reports
Indicator: Continued tracking of the nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software.
Measure: The number of reports generated and distributed to DMH staff and the OCS Advisory Council at least three quarterly reports and two annual reports.
Source(s) of Information: Data provided through the software, as calls to the OCS help line logged into the computer system.
Special Issues: Dissemination of the directory on disk (a read only version containing program information) is being provided only to DMH-certified and funded providers who sign a use agreement to ensure preservation of accurate and current data.
Significance: The establishment of a toll-free grievance telephone reporting system for the receipt (and referral for investigation) of all complaints by clients of state and community mental health/retardation facilities is a provision of the Mental Health Reform Act of 1997. The concurrent development of a computerized current database to also provide callers with information and assistance facilitates access to services by individuals expands the availability of current and detailed statewide service information to community mental health centers.
Funding: State General Funds

Anti-Stigma Campaign

According to SAMHSA the prevalence of serious mental health conditions in the 18-25 years of age group is almost double that of the general population, yet young people have the lowest rate of help-seeking behaviors. The Mississippi Department of Mental Health (DMH) and the Think Again Network will continue to address the stigma that is often associated with seeking care and to increase public awareness about the availability and effectiveness of mental health services through its Think Again campaign.

In October 2009, DMH and the statewide Think Again Network launched a campaign specific to Mississippi entitled, “Think Again.” The campaign is designed to decrease the negative attitudes that surround mental illness by encouraging young adults to rethink the way they view mental illness by shining the light on the truth of mental illness. Because the campaign targets the transitional age range, this transformation objective is included this year in both the Children’s Services and Adult Services State Plans. DMH established the Think Again Network with more than 40 representatives statewide from mental health facilities, community mental health centers, mental health associations, hospitals and other organizations in Mississippi. These representatives work within their area of the state by getting the word out about the campaign.

DMH is conducting has conducted a pro-active public relations campaign targeting newspapers, television and radio outlets. Mississippi’s Think Again efforts have joined forces with DMH’s Youth Suicide Prevention Campaign, “Shatter the Silence.” DMH is working with high schools and colleges across the state to reach students on campuses via articles in campus newspapers, interviews on college radio stations, presentations and the distribution of flyers and brochures on campus.
In October 2009, DMH and the Think Again Network launched the Think Again campaign which is an anti-stigma and mental health awareness campaign targeting young adults. Educational materials were developed for the campaign which focuses on the truths about mental illness, how to seek help, and how to fight stigma. Since Oct. 1, 2009, more than 18,000 Think Again brochures and 500 posters have been distributed. DMH worked with the Department of Education to send packets to more than 800 6th–12th grade public school nurses and counselors with a letter announcing the campaign and offering brochures, posters and presentations free of charge. As a result of the mail out, DMH received requests for more than 8,000 brochures. DMH has conducted more than 70 presentations statewide. DMH continues to combine the anti-stigma campaign efforts with the youth suicide prevention efforts. DMH conducted training in February to prepare 15 individuals to present the Think Again/Shatter the Silence presentations in their community and local schools. In October, several activities were conducted in conjunction with the campaign launch including Weems Community Mental Health Center’s Mind Matters event, Mississippi State Hospital’s Games Your Children Play Part II event, and Central Mississippi Residential Center’s Mental Health Awareness Event. Tougaloo College sent a text message to all their students announcing the campaign and offering mental health help. More than 20 television and radio interviews have been conducted and more than 70 newspaper articles have been printed reaching more than 900,000 Mississippians.

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 4th 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 FY10. 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.

DMH and the Think Again Network will be creating a website devoted to teens/college students. The website will include information about mental health and suicide prevention. The website will be promoted through the schools and colleges and will also include a section for both parents and teachers. Completion and availability of the website is planned for FY 2012.

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

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

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

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

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**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 — “Think Again”

**Indicator:** To reach 200,000 individuals during FY 2011

**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.

<table>
<thead>
<tr>
<th>MH Transformation PI Data Table</th>
<th>FY 2008 (Actual)</th>
<th>FY 2009 (Actual)</th>
<th>FY 2010 (Actual)</th>
<th>FY 2011 (Target)</th>
<th>FY 2012 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Individuals reached by Anti-stigma campaign</td>
<td>1.3 million reached</td>
<td>200,000</td>
<td>1.5 million</td>
<td>200,000</td>
<td>200,000</td>
</tr>
</tbody>
</table>

**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

**Multicultural Task Force**

The Multicultural Task Force coordinated by DMH has implemented major changes to address the cultural and linguistic diversity and cultural competency in the mental health field. The mission of the task force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. The task force membership was expanded to include a more diverse representation and input from various ethnic groups is continually solicited through contacts by task force members. Additional input from a new member who teaches graduate-level classes in multicultural counseling has also been helpful. There were 36 members on the task force during the development of the Cultural Competency Plan including representatives from the following agencies or organizations: community mental health center staff; individuals receiving services; Choctaw Behavioral Health; East Mississippi State Hospital; Parent Center Director; DMH (Divisions of Adult Services, Children Services, Mental Retardation, Alcohol and Drugs and Planning); Catholic Diocese; Assistant Director of Federal Programs, Rankin County Schools; Mississippi State Hospital; Catholic Charities Director and staff from the Immigration Services; NAMI-
Goal: To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force.

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

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

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

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
**Mississippi**

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

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

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

**Special Issues:** None

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

**Funding:** State funds

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**Cultural Competency Plan**

**Goal:** To develop a committee to guide the implementation of the Cultural Competency Plan to ensure culturally competent services are provided to individuals receiving services.

**Strategy:** Develop a committee to guide the implementation of the Cultural Competency Plan.

**Performance Indicator:** Meeting/activity by the Cultural Competency Workgroup

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

**Objective:** To develop a committee to guide the implementation of the Cultural Competency Plan to ensure culturally competent services are provided to individuals receiving services.

**Population:** Children with Serious Emotional Disturbance

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

**Brief Name:** Implementation Cultural Competency Workgroup

**Indicator:** Meeting/activity by the Cultural Competency Workgroup

**Measure:** The development of the committee and number of meetings

**Source(s) of Information:** Minutes of the workgroup meetings

**Special Issues:** None

**Significance:** The function of the workgroup is to guide the implementation of the
Local Provider Cultural Competence Assessment

The Multicultural Task Force has also coordinated use of a cultural competence assessment instrument at the local level in Regions 1, 3, 4, 6, 7, 8, 11, 14 and 15 in previous years. The long-range goal of this initiative is to provide local service providers with more specific information for use in planning to address needs identified through the assessment. DMH staff have continued to offer and/or provide follow-up consultation to local providers in developing recommendations based on assessment results. In FY 2009, Region 11 had received their local cultural competency assessment results and technical assistance in May 2009. By August 2010, Region 2 will complete the local cultural competency assessment. Results will be discussed with the region in by September 30, 2010.

Goal: 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.

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

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

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

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

Population: Children with Serious Emotional Disturbances

Criterion: Comprehensive, community-based mental health system.

Brief Name: Cultural competency pilot project expansion

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

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

Source(s) of Information: DMH Activity Reports

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

**Significance:** DMH Activity Reports

**Funding:** State and local funds

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

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

**Strategy:** Review of the CMHC Policy and Procedure manual will provide an opportunity for CMHCs to develop and implement policies and procedures in the area of cultural and linguistic competence that will enhance service delivery for all.

**Performance Indicator:** Staff in the Division of Children and Youth will review a minimum of five (5) CMHC Policy and Procedure Manuals per year.

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

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**Information Management Systems Development**

The Department of Mental Health will continue ongoing efforts to implement a more standardized system of computerized data collection, including data needed for reporting on the National Outcome Measures (NOMS) and data needed for reporting in the Uniform Reporting System tables requested by the federal Center for Mental Health Services (CMHS). The national Mental Health Statistics Improvement (MHSIP) Data Standards for Mental Health Decision Support Systems provided a foundation for development of a draft set of data standards within the agency. Beginning in 2001, the DMH has applied for and received three, Mental Health Data Infrastructure Grants (MH-DIG) from the CMHS to address a core set of data specified by the CMHS, to be reported in a set of tables referred to collectively as the Uniform Reporting System (URS) tables. The federal CMHS has worked over time with the states to develop and refine the URS tables, which include data from the public community mental health system, as well as data from the state psychiatric hospitals administered by the DMH. When completed, as currently proposed, the URS includes 21 tables, some of which include subsets, that are conceptualized to provide a profile of individuals with mental illness served by the public mental health system (such as demographic information, service funding support, satisfaction with services and outcomes) and a profile of the overall mental health system (such as expenditures, sources of funding and types of services provided). The National Outcome Measures (NOMS) developed by SAMHSA and to be addressed in State Community Mental Health Services Plans have been developed from data that was included in or added to the URS tables over time.
Mississippi

As mentioned, the DMH has used the DIG funds to support design, refinement and implementation of reporting systems that will facilitate community service providers’ and state psychiatric hospitals’ submission of data contained in the URS tables. DMH submitted the following URS tables to NRI/CMHS: 2A, 2B, 3, 4, 5A, 5B, 6, 8, 9A, 9B, 10, 11, 12, 14A, 14B, 15, 16(some EBPs), 17 (some EBPs), 19A, 19B, 20A and 20B. Table 1 and 13 information is provided by CMHS. A copy of the URS tables submitted to CMHS (and subsequent corrections) have also been provided to the MS State Mental Health Planning and Advisory Council as they are finalized. As described under Criterion 1, the DMH has continued to use DIG funds to support collection and reporting of consumer satisfaction survey information for adults and families of youth served by the public community mental health system. Consumer satisfaction survey information is also being collected to complete one of the URS tables (Table 11: Summary Profile of Client Perception of Care). As mentioned, beginning in 2006, the DMH also included additional items on the survey requested by CMHS to collect baseline information for other National Outcome Measures, including change in school attendance (URS Table 19A) and criminal justice or juvenile justice involvement (URS Table 19A), as well as developmental measures (social connectedness and functioning, in URS Table 9).

In FY 2011, efforts will continue to support transition from a system in which aggregated reports are generated at the local level and submitted to the state office, to one that would allow submission of data directly to the state office, referred to as a central data repository system. To date, most of the community mental health centers (CMHCs) and the state psychiatric hospitals and smaller nonprofit community mental health providers funded by DMH have summarized their detail data for State Plan related reporting and have sent only aggregate information to the DMH at its Central Office for submission to the National Research Institute, Inc. (NRI), which compiles the URS data nationally for CMHS. Historically, lack of uniformity and duplicated data across the various reporting providers’ local systems have been problematic in state-level reporting. To address these and other issues of data quality and timeliness, the DMH has been using the majority of its current CMHS Mental Health Data Infrastructure Grant (MH-DIG) to contract with Mississippi Information Technology Services (ITS) to develop a centralized data repository (CDR), which is designed to include information about individuals served who are uniquely identified and to house timely, accurate and well-defined information that is detailed to the client level from all DMH certified and funded providers. As a result, the DMH now has a CDR in place that is capable of housing unduplicated client data from all providers across the state. Approximately 67%, of regional community mental health centers (CMHCs), and 50%, of the state psychiatric hospitals are presently submitting data that passes edits and populates that database. The smaller nonprofit children’s services providers certified and funded by DMH to provide community mental health services (other than the CMHCs and hospitals) are not yet submitting data to the CDR. Plans for ongoing data infrastructure improvement include development of a browser based system for data entry from these organizations.

In 2010, DMH received funding of The Mississippi Mental Health Data Infrastructure Quality Improvement Project (FY 2011 – FY 2013) which will enable the Mississippi Department of Mental Health to continue work needed to build its infrastructure and refine its capacity to report quality data for the National Outcome Measures (NOMs) reported in the Mississippi State Plan for Community Mental Health Services and the related annual Implementation Report. The State Plan includes annual objectives to realize the agency’s vision for a comprehensive, community-based and recovery-oriented system of services and supports for adults with serious mental illness and children with serious emotional disturbances and their families. The project will focus on developing
infrastructure for reporting of client-level data for five targeted NOMs and for increasing
and improving reporting of other NOMs and Uniform Reporting System (URS) data
defined for the Community Mental Health Services Block Grant program. Goals of the
proposed project are: (1) Refine reporting of client-level data for targeted NOMs and
improving reporting of other NOMs/URS tables; (2) Ensure standard definition use; (3)
Refine data infrastructure for capturing, reporting, and storing URS data needed for
NOMs/URS reporting, including targeted client-level NOMs; (4) Develop/implement
specific strategies for improving data integrity; (5) Work with other stakeholders on
refinements and/or additions to the NOMs/URS system tables; and, (6) Improve
understanding and use of satisfaction survey data.

The DMH Division of Information Systems and Division of Planning staff will continue to
participate in CMHS conference calls and national meetings, held regularly to discuss the
development of the URS data tables. DMH staff also will communicate regularly with the
community mental health centers'/other providers’ data managers as progress on development of
the URS data tables continues. DMH Division of Information Systems and Division of Planning
staff will also continue work with programmatic staff at the state level in the Bureau of Mental
Health and at the local provider level to coordinate development of state plan reporting,
including National Outcome Measures for the CMHS Block Grant program.

In FY 2007, DMH received funding of the Mississippi Mental Health Data Infrastructure
Quality Improvement Project (FY 2008-FY 2010), which will enable the Mississippi Department
of Mental Health to continue activities to thoroughly and accurately provide unduplicated counts
for the Uniform Reporting System measures, including the National Outcome Measures as
required for the CMHS Block Grant program, to identify trends in services and outcomes, and
increase the involvement of stakeholders in planning. The goals of the proposed project are to:
(1) Refine the central data repository for public mental health system data; (2) Refine the
process for collection and reporting of information from consumer and family satisfaction surveys; (3)
Improve data quality assurance systems; and (4) Increase accessibility and use of URS/NOMs
measures and other mental health system data by the Mississippi State Mental Health Planning
Council, DMH staff and other stakeholders involved in planning and system improvement
activities. If its application for another three years of funding for the data infrastructure project
is approved, DMH will pursue project plans to refine and implement a strategic plan for
reporting client-level data for the National Outcome Measures targeted by CMHS, for refining
infrastructure and processes for data collection and reporting, as well as for improving data
integrity. Through continued data infrastructure development, quality assurance and technical
assistance activities described in this proposal, the integrity and completeness of timely, detailed
data to support measures for the Uniform Reporting System (URS) tables, including the National
Outcome Measures (NOMs), will be enhanced. Increased use of URS/NOMs measures, as well
as integration of the measures with other quality assurance information, will facilitate state
planning and performance improvements across the system of services and supports for
individuals with mental illness and their families.

DMH now has a central data repository (CDR) in place that is capable of housing
unduplicated client data from all providers across the state. Fourteen out of fifteen, or
93%, of regional community mental health centers (CMHCs) and four out of four, or
100%, of the state psychiatric hospitals are presently submitting data that populates the
Goal: To develop a uniform, comprehensive, automated information management system for all programs administered and/or funded by the Department of Mental Health.

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

- Continued contracting for development of a central data repository and related data reports to address community services and inpatient data in the Center for Mental Health Services (CMHS) Uniform Reporting System (URS) tables, consistent with progress tracked through the CMHS MH DIG Quality Improvement project;
- Periodic review and Revision of the DMH Manual of Uniform Data Standards;
- Continued communication with and/or provision of technical support needed by DMH Central Office programmatic staff who are developing performance/outcome measures;

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

- Ongoing communication with service providers, including the common software users group to assess technical assistance/training needs;
- Technical assistance/training related to continued development of uniform data systems/reporting, including use of data for planning and development of performance/outcome measures, consistent with the MH DIG Quality Improvement project;
- Technical assistance related to implementation of HIPAA requirements and maintenance of contact with software vendors.

Performance Indicator: Progress on tasks specified in the Indicator.

Description of Collecting and Measuring Changes in Performance Indicator:

Efforts to Increase Funding

Mississippi’s budget process is such that funds the Department of Mental Health requested in the 2010 legislative session, which began in January of 2010, would be made available for the fiscal year that begins July 1, 2010, and ends June 30, 2011. In its initial budget request for FYE 6/30/2011, the Department of Mental Health requested an increase of $56,030,731 (an increase of about 25½%). This requested increase was for all services provided through the Department (mental health services for adults and children, services to persons with substance abuse diagnoses, services to persons with intellectual and developmental disabilities, and services to persons with Alzheimer’s disease and other dementia; inpatient and outpatient services in all
areas). Included in that requested increase, which totaled $45 million, were (1) funding to replace loss of enhanced Federal share of Medicaid under the American Recovery and Reinvestment Act (about $13 million); (2) additional funding to fully fund Medicaid match for the CMHC program (about $30 million) and (3) funding to replace a reduction in grant funding (about $2 million). None of the requested increase was awarded. Additionally, the original general fund appropriation for FYE 6/30/10 (approximately $220,500,000) was cut to about $200,000,000 during the fiscal year due to declining tax revenues. This cut was taken entirely from residential and institutional based services. The financial situation for the next fiscal year (FYE 6/30/12) does not really appear any better. DMH will be addressing funding for that fiscal year during the legislative session that will begin in early January 2011.

Mississippi’s appropriations process is such that funding for state fiscal year that begins July 1, 2011 and ends June 30, 2012, was requested in a budget request submitted to the Joint Legislative Budget Committee on August 1, 2010. Hearings before that committee were held in September, and a recommended funding level was then established. (The recommended funding level is ALWAYS well below the request.) That recommended funding level became the starting place for the appropriations process that occurred during the 2011 legislative session, which ran for 90+ calendar days beginning in early January. The final appropriation bill was finally approved during a short special session in April.

DMH requested an increase of $47 million in state source funds. Of that amount, $17 million was to make up for the enhanced federal share of Medicaid for residential programs that was scheduled to cease July 1, 2011. Another $20 million was to fund the state’s one-half share of Medicaid match for community mental health services, none of which was funded during the year ending June 30, 2011. The other $10 million was to restore cuts and/or expand services, mostly in community programs. The final appropriation granted an increase of $29 million but requires DMH to cover $37 million of additional expenditures (the $17 million for loss of enhanced federal Medicaid and the $20 million for CMHC match), which will be accomplished through a combination of cuts to other programs and spending down cash balances.

The Justice Department recently began an investigation of the Mississippi Department of Mental Health to determine if Mississippi is violating the civil rights of consumers of mental health services. Mental health officials in Mississippi have been in contact with officials in Georgia concerning their experience with Justice, and they can also draw on their own experiences with Justice investigations of ICF/MR and nursing home programs.

Budget requests for the year that begins July 1, 2012 and ends June 30, 2013, are due August 1, 2011. Current plans are to request sufficient funding to maintain the level of operations that will occur during the year that begins July 1, 2011 in addition to sufficient funding to begin expanding community based services as outlined in the DMH Strategic Plan. A copy of that plan is available on the DMH website (www.dmh.state.ms.us). This plan has a heavy emphasis on expanding community services while concurrently reducing residential services. The main issue standing in the way is “bridge funding.” That is, to successfully move an inpatient to a community program one must first create the community program (which means there will be increased expenditures for a while because both the community program and the institutional program must exist for the transition period) and the client must also have an adequate place to live and access to transportation.
once discharged from residential care. Bridge funding will almost certainly be a part of the budget request.

DMH has also advised legislative leaders of the Justice investigation, and advised them that a supplemental budget request might be made to address findings if those findings are released during the legislative session.

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

**Strategy:** The Department of Mental Health will seek additional funds in its FY 2013 budget request for community support services for children with serious emotional disturbances and adults with serious mental illness.

**Performance Indicator:** Inclusion of request for increased state funds to support community mental health services for children in the FY 2013 DMH Budget Request.

**Description of Collecting and Measuring Changes in Performance Indicator:**
DMH Budget Request, FY 2012

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Note to Planning Council: The following sections were added in the new draft guidelines/instructions for development of the FY 2012-2013 State Plans. At this point in time, states are being given the option to expand these sections after the September 1, 2011 Plan submission deadline for required components; this is being referred to as a “rolling submission.” As you will note, DMH has drafted some of these optional sections that follow; other sections will be addressed and added before the submission deadline.

C. Use of Block Grant Dollars for Block Grant Activities
D. Activities that Support Individuals In Directing the Services
E. Data and Information Technology
F. Quality Improvement Reporting
G. Consultation with Tribes

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

An individual from the Choctaw Tribe, working in the area of youth and substance abuse, participated in the development of the DMH Cultural Competency Plan, as well as the National Minority Mental Health Awareness Event sponsored by the DMH (July 23, 2010). On March 25-26, 2010, a DMH staff member attended a conference on the reservation.
entitled, “Connecting Healthcare Providers and the Community to Improve Health Disparities Among Native Americans,” which was sponsored by the Delta Region, Southeast, and North Carolina AIDS Education and Training Centers. On January 7, 2010, this DMH staff member also participated on a Cultural and Linguistic Community of Practice conference call called “Transgenerational Trauma and Its Effects on Families and Communities” with speaker Dr. Eduardo Duran regarding Native Americans and their land issues. A woman who was raised on a reservation came to Mississippi from Lambda Legal to conduct a workshop for DMH administrators and service providers on Lesbian/Gay/Bisexual/Transexual Cultural Competency through the Technical Assistance Partnership.

DMH staff have received a request from the Mississippi Band of Choctaws for assistance in developing and providing FASD-specific education and training for case managers, social workers, and other staff within the Choctaw Tribal Agency. The primary goal of this effort will be to provide FASD prevention services to families and children within the Choctaw Tribal Agency. This expressed need has been included in the 2011-2013 FASD State Plan as an objective to be accomplished within the next two years. Mississippi’s FASD State Plan is developed and implemented by the Mississippi Advisory Council on FASD (MS AC-FASD) which is made up of representatives from at least fifteen state and local agencies and programs who have a direct interest and involvement in children and families who are affected by FASD.

H. Service Management Strategies
I. State Dashboards

J. Suicide Prevention

The DMH, working in collaboration with the Department of Defense and local authorities, has specific initiatives to promote mental health awareness by providing information to active duty military, veterans, National Guard members, the Reserve and family members of the military on accessing needed mental health services. The SMHA serves on the Joint Behavioral Health Task Force and developed the military campaign, *Operation Resiliency*, which focuses on mental health awareness for returning veterans and their family members. *Operation Resiliency* will reach all National Guard units across the state through brochures, posters, and resource guides and aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress, and share knowledge about available resources. Resource guides have been distributed to 500 men and women in the National Guard. In addition, the Bureau of Alcohol and Drug Abuse works closely with the Mississippi National Guard in prevention efforts with the MS public and private schools. A Colonel from the Guard serves on the State Alcohol and Drug Abuse Advisory Council.

The Youth Suicide Prevention Advisory Council was created in 2006 upon receipt of a grant from SAMHSA targeting the Gulf Coast Counties after Hurricane Katrina. The Council supported and approved a statewide plan for addressing suicide prevention in 2007. DMH submitted an application for a statewide Suicide Prevention Grant in 2009, which was not awarded. However, DMH submitted another application in 2011. The Council will begin revising and updating the Youth Suicide Prevention Plan in 2011. Since
2007, the Council assisted with the development of DMH’s Youth Suicide Prevention Campaign, “Shatter the Silence;” coordinated the first annual Youth Suicide Prevention Conference in 2008; coordinated a Youth Suicide Prevention Pre-Conference in 2008; supported the passage of Senate Bill 2770 in 2009 which calls for the Mississippi Department of Education to require local school districts to conduct in-service training on suicide prevention for all licensed teachers and principals. DMH, Division of Children and Youth Services continues to have two certified trainers in Applied Suicide Intervention Skills Training (A.S.I.S.T.) that train providers across the state including mental health professionals, social workers, youth court counselors, youth detention center staff and family partners. Finally, DMH’s Office of Constituency Services contracts with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in Mississippi. The federally funded NSPL routes callers from Mississippi to the DMH Office of Constituency Services for crisis intervention, suicide prevention, and resource referrals. (See Appendix A: Mississippi Youth Suicide Prevention Plan.)

K. Technical Assistance Needs

L. Involvement of Individuals and Families

How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?

The DMH offers a Certified Peer Specialist services and provides training and technical assistance to consumers and consumer groups to develop skills to aid other mental health consumers in their recovery. Drawing from their own insight into, and experience, with mental illness, CPSs through their similar experiences with mental illnesses give others encouragement, hope, assistance, and understanding that aids in recovery. The program prepares CPSs to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve and is an opportunity for consumers and family members to see that recovery is possible.

The DMH has 3 Consumer Coalitions covering all 15 mental health regions. The mission is to improve the lives of consumers of mental health services by providing educational training opportunities and ensure that consumers have a major voice in the development and implementation of mental health care at the State level and empowering people to recover and lead a full life in the community. The Clubhouse Coalition is made up of clubhouse members and staff who attend the clubhouse programs in the 15 mental health regions. Their mission is to support the enhancement and development of psychosocial rehabilitation programs (Clubhouses) in the State.

The Mental Health Planning and Advisory Council is made up of a balanced number (not less than 50%) of both service providers and non-service providers, including individuals who have or are receiving mental health services and family members. Primary responsibilities include planning and developing comprehensive mental health treatment, support, and rehabilitation services for all individuals. They are also responsible for monitoring, reviewing, evaluating and advising the allocation and adequacy of mental health services within the State.
Finally, individuals in recovery and family members participate in the on-site peer review visits to local child and adult mental health programs as part of the DMH’s peer review and monitoring process.

Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?

The Division of Consumer and Family Affairs, which is staffed largely by people who have utilized mental health services provides training to both service providers and individuals receiving services and reviews, evaluates, and enhance opportunities for consumers and family members to participate fully in all aspects of mental health services. The Division Consumer and Family Affairs Peer Support training 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.

The Multicultural Task Force addresses issues relevant to providing appropriate, culturally sensitive mental health services to minority populations in MS. The task force also provides statewide training using the National Coalition Building Institute’s Prejudice Reduction curricula.

Does the State sponsor meetings that specifically identify individual and family members’ issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The work of the Mental Health Planning Council committees, such as the Consumer Rights Committee and Children’s Services Task Force, involves examining and considering information on current services and service delivery processes. Their work to evaluate and learn about issues and needs regarding the mental health system typically leads to recommendations for improvements to the system, including new objectives in the State plan.

The Consumer Rights Committee focuses its efforts on identifying concerns regarding the rights of individuals receiving services and makes recommendations to the Planning and Advisory Council about possible solutions to address those concerns. Although some specific situations involving the rights of individuals may be discussed and even referred to other entities for possible resolution, the main purpose of this committee is to make recommendations to affect changes in the larger system. sharing information

The DMH’s Office of Constituency Services is responsible for documentation, investigation and resolution of all complaints/ grievances regarding state and community mental health/mental retardation facilities that are received from individuals receiving services, family members and the general public through the toll-free Helpline.
How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?

The Division of Consumer and Family Affairs’ operational objectives are: 1) to ensure the individuals and families are the driving force for improvements in the publicly funded mental health system; 2) to help individuals and their families participate in the decision making at all levels of our public mental health system; and 3) to promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services.

The Consumer/ Family Interest Form was designed to support and strengthen consumer and family member representation on DMH committees, workgroups and task forces. Family members and/or consumers of mental health services who are interested in participating on DMH committees, workgroups, and task forces complete the form and a copy is maintained at DMH. Individuals are assigned to workshops groups, task forces, committees, etc. based on personal interest and/or experience on an as needed basis.

How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The Division of Consumer and Family Affairs financially supports non-profit organizations that provide peer-directed mental health recovery services to consumers. Through training, technical assistance, and monthly reporting, DMH assists these organizations in their efforts to provide quality peer support services, run by and for consumers of mental health services. NAMI-MS provides family education (Family-to-Family) programs and support groups to help family members learn essential skills and information related to caring for a family member diagnosed with a mental illness and consumer education programs (Peer to Peer) to consumers diagnosed with a mental illness. Drop-in Centers provide a wide range of services to consumers of mental health services which include social and recreational programs, information and referral, consumer education and advocacy, with a strong emphasis on empowering and involving consumers of mental health services in providing support to others.

Mississippi Mental Health Recovery Social Network is a social network for the mental health community founded by certified peer specialists, consumers of mental health services and representatives of the Department of Mental Health. The primary purpose of Mississippi Recovery Network is to connect individuals affected by mental illness. Participants can use the Network to connect with others who share similar stories, experiences, and goals and other topics of interest; find resources and get support on mental health issues; engage in positive discussion around mental health with forums, blogs, and community groups; search for and collaborate in producing information; and keep track of upcoming events like training courses, exhibitions, group meetings, seminars, and conferences.

We are also fortunate to have the Mississippi Leadership Academy, which has proven successful for adults with mental health and/or co-occurring concerns because it emphasizes the importance of peer-support, responsibility, empowerment and recovery-
It is beneficial to the community-at-large by supporting collective advocacy, increasing networking and greater civic involvement, and improving awareness of and action on local issues and concerns. The comprehensive training curricula allows consumers and family members to obtain skills necessary for improving their quality of life, collective advocacy, proactive leadership, information sharing, and effectively leading groups of individuals to accomplish goals.

M. **Use of Technology**

N. **Support of State Partners**
Appendix A
Mississippi Youth Suicide Prevention Plan

SPONSORED BY THE
MS DEPARTMENT OF MENTAL HEALTH
DIVISION OF CHILDREN AND YOUTH

Funded, in part, through a grant from Substance Abuse
and Mental Health Services Administration, Department of
Health and Human Services
I. OVERVIEW

A. Introduction

In 2006, the MS Department of Mental Health, Division of Children and Youth, received a grant from the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, to develop and implement statewide suicide prevention and early intervention activities to benefit youth who were adversely impacted by Hurricane Katrina.

A part of the grant structure and governance was the development of a grant advisory council. Although the project’s original intent was to strengthen the state’s response to the mental health needs of youth ages 10-24 in six gulf coast counties most adversely affected by the storm, the newly established council subsequently supported and approved the development of a state-wide plan for addressing suicide prevention. In addition to the advisory council’s duties and role of providing leadership and insight
for the implementation of the Federal grant, this Mississippi Youth Suicide Prevention Advisory Council (Council) also developed Mississippi’s first comprehensive plan for youth suicide prevention.

A professional services firm, the Parham Group, was retained to lead and guide the development of this first state-wide plan. The process used by the Parham Group included extensive research on national and state statistical data and suicidal causes, treatment, and awareness information; review of the National Strategy for Suicide Prevention, as well as other state plans; personal interviews with Council members; open discussions with the Council; correspondence with Council members; and review of draft plan documents with the Council.

B. Purpose
Approximately 349 Mississippians youth die each year from suicide. With a suicide rate of 12 per 100,000 population, Mississippi ranks 23 out of the 50 states (ranges from Alaska at 23/100,000 to DC with 6/100,000). Of these suicides, 54 are youth ages 15-24, making suicide the 2nd leading cause of death among this age group in the state. On average, there are 1,343 hospitalizations in Mississippi each year because of attempted suicide. Nearly 200 of these were youth ages 15-19. 1

According to the 2005 Centers for Disease Control’s Youth Risk Behavior Survey, 25% of middle school-age children in the state reported seriously considering suicide (compared to the national average reported in the YRBS of 17%); 18% of Mississippi middle school-age children reported making a plan to kill themselves (compared to the national average of 17%); and 11.7% of middle school children reported that they had attempted suicide in the past 12 months (compared to national average of 8.5%). 2

It is the intent that led and organized through this plan, Mississippi will have an increased capacity to better intervene and respond to its youth who are hurting to the point of taking/attempts to take their own lives, through increased awareness and understanding of this menacing problem threatening our youth. We hope to shed the stigmatism and silence surrounding it, increase the training of community “gatekeepers”, and promote effective clinical and professional practice.

C. Target Population
The target population for this state-wide plan is adolescents and young adults, ages 10-24, in Mississippi.

D. Expected Outcomes
Ultimately, the goals of this plan are: (1) a reduction in completed suicides by Mississippi youth by 2010; and (2) a reduction in youth hospitalizations resulting from suicide attempts by 2010. Ideally, the most effective means of accomplishing these goals is to remove the underlying or root cause of the pain suffered by youth who seriously consider suicide. Realistically, however, this approach alone would not only be extremely difficult to implement, but would also take a very long time to have any meaningful impact – time that some youth idealizing suicide do not have. Therefore, this plan outlines ten (10) relatively short-term objectives that we feel, if implemented appropriately, will effectively move the state toward successful
II. Mississippi Youth Suicide Prevention Advisory Council Members

1. Kim Saggis, Jason Foundation
2. Dr. John Fontaine, Child Psychologist
3. Roderick Richardson, MS State Department of Health
4. Dr. Michael Mann, Assistant Professor, Psychology & Counseling, Mississippi College
5. Regina Ginn, State Department of Education
6. Kelly Wilson, Catholic Charities of Jackson
7. Patti Marshall, Office of MS Attorney General
8. Gwen Winters, State Department of Health
9. Sandra Parks, MS Department of Mental Health
10. Mardi Allen, Ph.D., MS Department of Mental Health
11. Erin Gallagher, Gulf Coast Mental Health Center
12. Teresa Mosely, Family Representative
13. Sharon Grisham-Stewart, Hinds County Coroner
14. Leslie Sullivan, Youth Representative

Advisory Members

1. Kris Jones, MS Department of Mental Health, Division of Disaster Preparedness & Response
2. Shelley Foreman, Gulf Coast Mental Health Center
3. Martha Garrett, Catholic Charities of Jackson
4. Jackie Chatmon, MS Department of Mental Health, Division of Children & Youth Services
5. Buddy Parham, Parham and Associates
6. Chelley Barnes, Mississippi Department of Education

III. Suicide-Related Facts and Information for Adolescents and Young Adults

A. Key Statistics: Nationally

- About 2 million adolescents attempt suicide each year in the US. Almost 700,000 of these require hospitalization resulting from their attempt. 19% of high school students reported they have considered suicide, 15% have made a plan to complete suicide, and about 9% of all high school students have attempted suicide. 3

- Suicide is the 3rd leading cause of death in the US for adolescents and young adults accounting for 11.2% (4,232) of all deaths for this age group. 4

- Young white males are much more likely to complete suicide than young black males and 5 times higher than peer females of any race. However, females are more likely to attempt suicide. Only American Indian/Alaskan Native males have a higher suicide rate (more than 2 times higher). Black females are the least likely to complete suicide in this age group. 5
Within the age group, the suicide death rate for adolescents ages 10-14 is 1.7/100,000, for 15-19 year olds the rate is 8.9/100,000, and for 20-24 year old young adults, the suicide death rate is 13.6/100,000.  

Suicidal behaviors in young adults are usually the result of a process that involves multiple social, economic, family, and individual risk factors. More than 90% of all youth suicide victims have at least one major psychiatric disorder.  

Firearms (60%) and hanging (26%) were the two most common methods of suicide by youth ages 10-24.  

The most prevalent risk factors for suicide for adolescents and young adults are depression/hopelessness or other mental health issues, impulsive or aggressive tendencies, a sense of isolation, substance abuse, history of trauma or abuse, parental separation, and relational or social loss. Studies are showing that there is an increased risk for suicide among youth reporting gay/lesbian/bisexual orientation, especially for males.  

Key Statistics: Mississippi  
In Mississippi, approximately 54 youth ages 15-24 complete suicide each year.  
Suicide is the 2nd leading cause of death in MS for this (15-24) age group.  
Reflecting the national statistics, males are much more likely (83%) to complete suicide in MS than peer females (17%). Similarly, 83% of all youth suicides in MS are completed by white youth (any sex). Thus, of the 54 deaths by suicide (15-24 age group) in 2005 in MS, 37, or 68%, were white male, 8 (15%) were white female, 15 (8%) were nonwhite male, and 1 (less than 2%) were nonwhite female.  
The use of a Firearm is the most common method of suicide as well.  

B. Risk Factors for Suicide  
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders  
- Alcohol and other substance use disorders  
- Hopelessness  
- Impulsive and/or aggressive tendencies  
- History of trauma or abuse  
- Major physical illness  
- Family history of suicide  
- Relational or social loss  
- Easy access to lethal means  
- Lack of social support and/or a sense of isolation  
- Barriers to accessing health care, especially mental health and substance abuse treatment  
- Exposure to, including through the media, and influence of others who have died by suicide
C. Protective Factors for Suicide
- Effective clinical care for mental, physical, and substance use disorders.
- Easy access to a variety of clinical interventions and support for help-seeking.
- Restricted access to highly lethal means of suicide.
- Strong connections to family and community support.
- Support through ongoing medical and mental health care relationships.
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self-preservation. 15

D. Warning Signs for Teen and Young Adult Suicide
- Talks about committing suicide
- Has trouble eating or sleeping
- Experiences drastic changes in behavior
- Withdraws from friends and/or social activities
- Loss of interest in hobbies, school, activities
- Gives away prized possessions
- Had recent severe social/relational loss
- Is preoccupied with death and dying
- Loss of interest in personal appearance
- Increased use of alcohol or drugs 16

E. How to Help Someone Who is Thinking about Suicide
Suicide is not about wanting to die, but rather about a powerful need for pain to end. People choose suicide because they feel unable to cope with feelings of pain, hopelessness, helplessness, isolation, and uncertainties. Studies indicate that the best way to prevent suicide is through the early recognition and treatment of depression and other psychiatric illnesses that lead to suicidal tendencies. People who want to die by suicide almost always suffer from isolation and loneliness. You can help them simply by reaching out, listening, and letting them know you care. Often, with time and the help of others, suicidal feelings do pass. 17

Specific actions that may help if you know or suspect someone is considering suicide include:
- Be direct. Talk openly about suicide.
- Be willing to listen.
- Be non-judgmental.
- Get involved and be available.
- Don’t act shocked.
- Offer hope of alternatives.
- Do not be sworn to secrecy. Seek help.
- Take action. Remove access to guns, stockpiled pills, or other threats. 18

IV. Identified Issues/Needs/Gaps/Problems:
- Lack of structured, organized, comprehensive effort that heightens the importance and urgency of addressing youth suicide prevention
Lack of awareness about severity, causes, indicators, etc. associated with suicide by public, parents, youth
Lack of understanding, knowledge, and skill of “gatekeepers” to identify and effectively intervene
Lack of holistic, systemic protocol (procedure, process) to access appropriate resources needed address underlying risk factors
Social stigma/shame of suicide, suicide attempts, suicidal ideation
Social pressure of “not measuring up”, fear of failing
Involve youth more in prevention process (increase awareness and knowledge; web-based interactive tool for screening, assessing, and information sharing, how to intervene, etc.)
Improve surveillance (statistical data collection and observation) regarding youth suicide and suicide attempts (to be more accurate, more information, etc.)

V. Focus Areas, Goals, Objectives, & Strategies
As a result of the research and interviews performed during the development of this plan, three primary focus areas have emerged: Structure, Awareness, and Intervention. Itemized on the following pages are the goals, objectives, and strategies that collectively address and support each of these focus areas.

FOCUS AREA 1: STRUCTURE

GOAL I: Mississippi will Address the Issue of Youth Suicide through a Structured and Sustainable Means.

Objective A: Establish a lead entity to assume responsibility for the development of a comprehensive and coordinated system of information and intervention efforts for the prevention of youth suicide.

Strategy 1: Define the purpose, structure and governance of the entity
Strategy 2: Identify and recruit key, diverse members
Strategy 3: Develop and adopt bylaws
Strategy 4: Elect/appoint officers
Strategy 5: Establish action plan to guide efforts

Objective B: Maintain established entity to lead and coordinate ongoing youth suicide prevention efforts.

Strategy 1: Identify & seek appropriate funding opportunities to sustain youth suicide prevention efforts.
Strategy 2: Develop a system for ongoing evaluation for informational
and intervention efforts.

Strategy 3: Conduct and/or contract for relevant research and studies

Strategy 4: Coordinate/integrate efforts with any other ongoing programs, services, and information.

Strategy 5: Identify and promote expanded surveillance that captures relevant information/data regarding youth suicides in the state.

**FOCUS AREA 2: AWARENESS**

**GOAL II: Awareness Of and About Youth Suicide and Its Prevention will be Significantly Increased.**

**Objective A:** Develop a statewide public information and education campaign, that, among other things, reduces the stigma of and sensitivity to suicide.

*Resources would include (1) Jason Foundation school-based curriculum for youth, parent seminars, and staff development seminars; and (2) Youth Suicide Prevention Program’s state-wide public education and community action toolkit and media relations reporting guidelines.*

Strategy 1: Determine message, focus, and means of information dissemination

Strategy 2: Use public media (tv, radio, billboards, newspaper)

Strategy 3: Developed and disseminate materials (brochures, flyers, videos)

Strategy 4: Initiate an active website

Strategy 5: Conduct presentations at clubs, conferences, trainings, etc.

Strategy 6: Integrate suicide prevention message with other public information campaigns (substance abuse depression, violence prevention, gun safety)

Strategy 7: Develop and incorporate strategies to reduce the stigma associated with being a consumer of mental health services.

Strategy 8: Seek funding for implementation of the marketing plan.

Strategy 9: Train and partner effectively with the media

Strategy 10: Disseminate information about suicide prevention hotlines that are available (Lifeline 1-800-273-TALK, 1-800-SUICIDE, etc)
Objective B: Develop a suicide prevention clearinghouse, including current and relevant statistics, lending library, practice guidelines, success stories, “promising preventive methods and technologies”, and speakers’ bureau

Strategy 1: Collect and organize appropriate and necessary materials, information, etc.

Strategy 2: Establish process for access to materials/information by youth, professional, parents and community members

Strategy 3: Recruit and train presenters

Strategy 4: Update and maintain website

Objective C: Evaluate public awareness campaign by measuring increase in knowledge, skills, and attitude of public, parents, youth, and professional staff.

Strategy 1: Develop pre and post evaluation tool to measure desired awareness outcomes.

Strategy 2: Identify evaluation participants

Strategy 3: Administer evaluation tool prior to and after campaign.

Strategy 4: Report findings

FOCUS AREA 3: INTERVENTION

GOAL III: Appropriate and Effective Youth Suicide Prevention Strategies will be Developed, Implemented, and Evaluated.

Objective A: Implement “gatekeeper” professional training for the assessment, treatment, and management of suicidal youth, including:

- “SOS” (signs of suicide),
- Jason Foundation,
- Trauma-focused Cognitive Behavioral Therapy (Catholic Charities),
- Youth Suicide Prevention Program’s “gatekeeper” training curriculum.

Gatekeepers“ are those professionals in the community who have the opportunity to detect the conditions that lead to suicide and assist in obtaining help, i.e., school personnel; mental health, healthcare, social service, and juvenile justice professionals; and clergy.

Strategy 1: Promote “gatekeeper” professional school Curriculum to
include/improve/enhance the recognition and treatment of suicidal behavior in youth.

Strategy 2: Encourage gatekeeper professional certification programs to include **continuing education** on youth suicide issues and prevention.

Strategy 3: Make available youth suicide prevention training and education opportunities through conferences, seminars, workshops, and electronic venues for (a) mental health, (b) social service, (c) juvenile justice, and (d) health care professionals, and (e) clergy and other youth ministry personnel.

Strategy 4: Utilize therapists at all 16 CMHCs to intervene and treat referred youth using the “learning collaborative approach”.

Strategy 5: Identify training opportunities for clinical professionals.


**Objective B**: Enhance/promote effective clinical and professional practices

Strategy 1: Endorse and recommend and/or develop appropriate screening tools to assess depression, anxiety, stress, aggression, coping and problem solving skills, history of trauma/abuse, substance abuse, and other socio-cultural and environmental stressors.

Strategy 2: Promote better access to and use of informal mental health screening and support better linkages with and access to mental health services.

Strategy 3: Develop “best practices” guidelines; policies, procedures, and aftercare protocols.

Strategy 4: Develop and provide education for families of youth receiving care for psychiatric disorders, physical/sexual abuse, previous attempted suicide, excessive use of antidepressants, recent intense crisis (loss of loved one) or social “fitting” issues (gay/lesbian, bullied)

Strategy 5: Foster and promote continuity of care among consumers, treatment, education, and service sectors; and help overcome barriers to information sharing and collaboration.

**Objective C**: Promote and help develop youth/young adult suicide prevention programs throughout the state.
Strategy 1: Design (use/modify existing) and facilitate the implementation of:

a. Evidence-based projects/activities in public and private schools designed to address serious adolescent stressors that may lead to youth suicide;
b. Evidence-based projects/activities in colleges designed to address serious young adult stressors that may lead to suicide;
c. Evidence-based suicide prevention projects/activities in youth courts/detention centers;
d. Evidence-based projects/activities for youth/family service providers that identify and address serious stressors that may lead to youth suicide;
e. Evidence-based projects/activities for mental health providers that identify and address serious stressors and risk factors that may lead to youth suicide.

Strategy 2: Develop a high school and/or college anonymous, interactive, web-based screening tool that identifies those most at-risk for suicide and encourages to get treatment based on one developed by American Foundation for Suicide Prevention and piloted at Emory and University of North Carolina.

Objective D: Reduce access by youth to lethal methods of self-harm

Strategy 1: Develop as part of the public information campaign a component directed at families that is designed to reduce accessibility to lethal means, (guns, prescription drugs, etc.)

Objective E: Evaluate intervention methodologies through observable evidence and/or assessment tools, surveys, and interviews.

Strategy 1: Measure “gatekeeper” knowledge, skill, and attitude before and after training;

Strategy 2: Measure the development, use, and outcome of screening tools;

Strategy 3: Identify “best practices” development and utilization by professionals;

Strategy 4: Identify the development and use of specialized education for family members with high-risk youth incorporated into mental health practice;

Strategy 5: Identify the development, implementation, and utilization of suicide prevention projects and activities in the various disciplines;
Mississippi

(The outcome, or results, of the individually-developed projects/activities will be an organizational/discipline-specific responsibility. This proposed plan would cover the review and dissemination of the outcomes however.)
**LOGIC MODEL**
**MISSISSIPPI YOUTH SUICIDE PREVENTION PLAN**

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>INPUTS</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>School &amp; Community “gatekeepers”</td>
<td>Marketing Campaign planning</td>
<td>Create campaign and media materials</td>
<td><strong>Individual level</strong></td>
<td></td>
</tr>
<tr>
<td>Youth</td>
<td>Mkt. Campaign implementation</td>
<td>Utilization of materials</td>
<td>- Increased awareness of YSP</td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>Collect, organize, and disseminate SP materials, website, speakers, and other inf</td>
<td>Presentations made school &amp; community settings</td>
<td>- Increased knowledge of YSP</td>
<td></td>
</tr>
<tr>
<td>Mental Health &amp; Health Providers</td>
<td>Capacity Building Activities <em>(training, education, TA, tool development, clinical practice, etc.)</em></td>
<td>Youth /community members exposed to SP message</td>
<td>- Increased willingness to help youth</td>
<td></td>
</tr>
<tr>
<td>Jason Foundation</td>
<td>Collaboration among consumer, treatment, education, and service sectors</td>
<td>Youth, gatekeepers, &amp; families educated and trained, become more knowledgeable and better prepared</td>
<td>- Acquisition of helping behaviors</td>
<td></td>
</tr>
<tr>
<td>National resources</td>
<td>Development of evidence-based school, family, and community SP projects/activities</td>
<td>Improved practices and continuity of care</td>
<td><strong>School Level</strong></td>
<td></td>
</tr>
<tr>
<td>YSP Advisory Bd.</td>
<td></td>
<td>Website established</td>
<td>- Enhanced involvement by staff, teachers, parents and youth</td>
<td></td>
</tr>
<tr>
<td>SP materials, website &amp; other information</td>
<td></td>
<td></td>
<td>- Increased awareness and acknowledgment of youth suicide</td>
<td></td>
</tr>
<tr>
<td>Training providers</td>
<td></td>
<td></td>
<td>- More informed supportive atmosphere</td>
<td></td>
</tr>
<tr>
<td>Marketing tools/resources</td>
<td></td>
<td></td>
<td>- Adoption of new policies / procedures addressing youth suicide</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td></td>
<td><strong>Community Level</strong></td>
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</table>

**GOALS**
- Reduce youth suicide behavior
- Reduce youth suicide attempts
- Reduce number of deaths from youth suicide
SUICIDE IDEATION & BEHAVIOR AMONG YOUTH 2005

- Considered Suicide: 25% (Mississippi) vs. 17% (United States)
- Made Suicide Plan: 17% (Mississippi) vs. 16.5% (United States)
- Attempted Suicide: 11.7% (Mississippi) vs. 8.5% (United States)
## MISSISSIPPI YOUTH SUICIDE PREVENTION PLAN
### YEAR 1
(July 1, 2007 – June 30, 2008)

<table>
<thead>
<tr>
<th>Strategies Outcome</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define purpose, function, and governance of the lead entity to address suicide prevention</td>
<td></td>
</tr>
<tr>
<td>a. Identify and recruit members</td>
<td></td>
</tr>
<tr>
<td>b. Develop and adopt bylaws</td>
<td></td>
</tr>
<tr>
<td>c. Elect/appoint officers</td>
<td></td>
</tr>
<tr>
<td>d. Establish action plan to guide efforts</td>
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<tr>
<td>2. Conduct research to identify evidence-based projects and activities for schools, colleges, youth courts, CMH centers, healthcare facilities, and families.</td>
<td></td>
</tr>
<tr>
<td>a. Plan evidence-based projects/activities</td>
<td></td>
</tr>
<tr>
<td>b. Begin developing projects/activities</td>
<td></td>
</tr>
<tr>
<td>c. Coordinate/integrate efforts with other programs</td>
<td></td>
</tr>
<tr>
<td>3. Determine marketing plan: message (prevalence, indicators, stigma, access to lethal means, etc.); audience(s); and identify most effective means to disseminate information</td>
<td></td>
</tr>
<tr>
<td>a. Integrate message with other public info. campaigns as appropriate</td>
<td></td>
</tr>
<tr>
<td>b. Begin collecting materials and other suicide prevention information and resources</td>
<td></td>
</tr>
<tr>
<td>c. Implement non-expense items of mkt plan (presentations/seminars, existing materials, resources, curriculum, toolkits, and PSAs)</td>
<td></td>
</tr>
<tr>
<td>d. Identify and seek funding for market campaign</td>
<td></td>
</tr>
<tr>
<td>4. Promote and begin facilitating “gatekeeper” training and effective clinical/professional practice opportunities</td>
<td></td>
</tr>
<tr>
<td>a. Utilize Jason Fnd., YSPP, S.O.S.,</td>
<td></td>
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</tbody>
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### Mississippi

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<thead>
<tr>
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<tbody>
<tr>
<td><strong>A.S.I.S.T., trauma-focused cognitive behavioral therapy resources, and others.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>b. Initiate the “learning collaborative approach” with therapists at all CMHCs in the state to intervene and treat referred youth.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c. Identify and recommend appropriate screening tools to better assess psychological, socio-cultural, and environmental stressors that may trigger a suicide attempt.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>5. Identify and develop evaluation criteria and methodology</strong></td>
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MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
BUREAU OF ALCOHOL AND DRUG ABUSE

FY 2012 - 2013 STATE PLAN

Draft

Presented by:

Mr. Herbert Loving, Bureau Director

Ms. Ginger Steadman, Director of Treatment Services

July 21, 2011
**FY 2012 – 2013 ALCOHOL AND DRUG ABUSE STATE PLAN**

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PURPOSE OF THE PLAN

The purpose of the State Plan for Substance Abuse Services is:

• to describe the comprehensive, community-based service delivery system for individuals with substance abuse upon which program planning and development are based;

• to set forth annual goals/objectives to address identified needs;

• to assist the public in understanding efforts employed and planned by the Department of Mental Health to provide supports to Mississippi’s citizens with substance abuse;

• to serve as a basis for utilization of federal, state and other available resources; and

• to provide through the establishment of an Alcohol and Drug Abuse Advisory Council, an avenue for individuals, family members and service providers to work together in identifying and planning an array of services and supports through the annual update of this Plan.

The State Plan’s implementation time period is October 1, 2011 – September 30, 2013. Since the Plan is considered a working document, it is subject to continuous review and revision. The public is encouraged to review the Plan and submit comments by August 9, 2011.

MS Department of Mental Health
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Jackson, MS 39201
Phone: (601)359-1288 TDD: (601)359-6230
FAX: (601)359-6672

Comments regarding the FY 2012-13 State Plan submitted after August 9, 2011 will be considered in development of the FY 2014 State Plan.
BUREAU OF ALCOHOL AND DRUG ABUSE

DMH MISSION STATEMENT

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities one person at a time. The Bureau of Alcohol and Drug Abuse is committed to this mission and maintains a statewide comprehensive system of substance abuse services of prevention, treatment and rehabilitation and promotes quality care, cost-effective services and ensures the health and welfare of individuals through the reduction of substance abuse.

DMH VISION STATEMENT

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

A better tomorrow exists when…

• All Mississippians have equal access to quality mental health care, services and supports in their communities.

• People actively participate in designing services.

• The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse and dementia has disappeared.

• Research, outcomes measures and technology are routinely utilized to enhance prevention, care, services and supports.

In an effort to support this vision, the Bureau of Alcohol and Drug Abuse will promote the highest standards of practice and the continuing development of substance abuse programs.
Core Values and Guiding Principles of the Department of Mental Health

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

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

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

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

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

**Collaboration:** We believe that services and supports are the shared responsibility of state and local governments, communities, families, and service providers. Through open communication, we continuously build relationships.

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

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

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

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

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

The State Public Mental Health Service System

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

Organizational Structure of the Mississippi Department of Mental Health

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

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

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

DMH has seven bureaus: the Bureau of Administration, the Bureau of Mental Health, the Bureau of Community Mental Health Services, the Bureau of Alcohol and Drug Abuse, the Bureau of Intellectual and Developmental Disabilities, the Bureau of Interdisciplinary Programs, and the Bureau of Workforce Development and Training.

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

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

The Bureau of Alcohol and Drug Abuse is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems, including state Three-Percent Alcohol Tax funds for DMH. The overall goal of the state's substance abuse service system is to provide a continuum of community-based, accessible services, including prevention, outpatient, detoxification, community-based primary and transitional residential treatment, inpatient and aftercare services. The Bureau includes two divisions, the Division of Prevention Services and the Division of Treatment Services.

The Bureau of Mental Health oversees the six state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services as well as the Central Mississippi Residential Center.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for individuals in the state with intellectual and developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive regional centers for individuals with intellectual and developmental disabilities, one juvenile rehabilitation center for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services. The Bureau of IDD includes two divisions, the Division of Home and Community-Based (HCBS) ID/DD Waiver and the Division of Early Intervention Services.

The Bureau of Interdisciplinary Programs works with all other DMH programmatic bureaus, DMH facilities, DMH certified programs. The Bureau of Interdisciplinary Programs facilitates and coordinates the collection of information to develop reports, formulate policies, rules and regulations as necessary for the Board of Mental Health and Executive Director; develops strategies for project management and organization; and, completes special projects for the Board of Mental Health and DMH. The Bureau Director of Interdisciplinary Programs serves as the liaison to the Board of Mental Health and provides administrative leadership in the planning, directing and coordinating of the Board of Mental Health and DMH Strategic Plan.

The Bureau of Workforce Development and Training advises the Executive Director and State Board of Mental Health on the human resource and training needs of the agency, assists in educating the Legislature as to budget needs, oversees the leadership development program, and serves as liaison for DMH facilities to the State Personnel Board. This Bureau includes two divisions, the Division of Professional Development and the Division of Professional Licensure and Certification.

Functions of the Mississippi Department of Mental Health

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

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

**State Role in Funding Community-Based Services:** DMH’s funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, DMH is a general state tax fund agency.

Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health.

**Service Delivery System**

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

**State-operated facilities:** DMH administers and operates six state psychiatric facilities, five regional centers for people with IDD, and a juvenile rehabilitation facility. These facilities serve specified populations in designated counties/service areas of the State.

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

The Regional Centers provide on-campus residential services for persons with intellectual and developmental disabilities. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

The Mississippi Adolescent Center (MAC) in Brookhaven is a residential facility dedicated to providing adolescents with intellectual and developmental disabilities an individualized array of rehabilitation service options. MAC serves youth who have a diagnosis of intellectual and developmental disabilities and whose behavior makes it necessary for them to reside in a structured therapeutic environment. The Specialized Treatment Facility in Gulfport is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment.
State-operated Community Service Programs: All of the psychiatric hospitals and regional centers provide community services in all or part of their designated service areas. Community services include: residential, employment, in-home, and other supports to enable people to live in their community.

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

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

Available Services and Supports

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

Facility Services

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

- Acute Psychiatric Care
- Intermediate Psychiatric Care
- Continued Treatment Services
- Adolescent Services
- Community Service Programs
- Nursing Home Services
- Medical/Surgical Hospital Services
- Forensic Services
- Alcohol and Drug Services

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

- ICF/MR Residential Services
- Psychological Services
- Social Services
- Medical/Nursing Services
- Diagnostic and Evaluation Services
- Special Education
- Recreation
- Speech/Occupational/Physical Therapies
- Vocational Training/Employment
- Community Services Programs
**Community Services**

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

**Services for Adults with Mental Illness**

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**Services for Children and Youth with Serious Emotional Disturbance**

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<td>School Based Services</td>
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<td>Mental Illness Management Services</td>
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<td>Individual Therapeutic Support</td>
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<td>Family Education and Support</td>
<td>Acute Partial Hospitalization</td>
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**Services for People with Alzheimer’s Disease and Other Dementia**

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<tr>
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<tr>
<td>Adult Day Centers</td>
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**Services for People with Intellectual/Developmental Disabilities**

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<td>Community Living Programs</td>
<td>HCBS Behavioral Support/ Intervention</td>
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<td>Work Activity Services</td>
<td>HCBS Community Respite</td>
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<tr>
<td>Supported Employment Services</td>
<td>HCBS In-home Companion Respite</td>
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<td>Day Support</td>
<td>Day Treatment</td>
</tr>
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</table>

13
HCBS In-home Nursing Respite
HCBS ICF/MR Respite
HCBS Day Habilitation
HCBS Prevocational Services
HCBS Support Coordination
HCBS Occupational, Physical, and Speech/Language Therapies

Services for Substance Abuse

Chemical Dependency Services
Detoxification Services
DUI Diagnostic Assessment
Outpatient Services
Outreach/Aftercare Services
Prevention Services
Primary Residential Services
Transitional Residential Services
| Region 1: Coahoma, Quitman, Tallahatchie, Tunica | Region One Mental Health Center  
Karen Corley, Interim Executive Director  
1742 Cheryl Street  
P. O. Box 1046  
Clarksdale, MS 38614  
(662) 627-7267 |
|---|---|
| Region 2: Calhoun, DeSoto, Lafayette, Marshall, Panola, Tate, Yalobusha | Communicare  
Michael D. Roberts, Ph.D., Executive Director  
152 Highway 7 South  
Oxford, MS 38655  
(662) 234-7521 |
| Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union | Region III Mental Health Center  
Robert J. Smith Executive Director  
2434 South Eason Boulevard  
Tupelo, MS 38801  
(662) 844-1717 |
| Region 4: Alcorn, DeSoto, Prentiss, Tippah, Tishomingo | Timber Hills Mental Health Services  
Charlie D. Spearman, Sr., Executive Director  
303 N. Madison Street  
P. O. Box 839  
Corinth, MS 38835-0839  
(662) 286-9883 |
| Region 5: Bolivar, Issaquena, Sharkey, Washington | Delta Community Mental Health Services  
Richard Duggin, Interim Executive Director  
1654 East Union Street  
P. O. Box 5365  
Greenville, MS 38704-5365  
(662) 335-5274 |
| Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower | Life Help  
Madolyn Smith, Executive Director  
Old Browning Road  
P. O. Box 1505  
Greenwood, MS 38935-1505  
(662) 453-6211 |
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<tr>
<th>Region 7:</th>
<th>Community Counseling Services</th>
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<tbody>
<tr>
<td>Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston</td>
<td>Jackie Edwards, Executive Director</td>
</tr>
<tr>
<td></td>
<td>302 North Jackson Street</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 1188</td>
</tr>
<tr>
<td></td>
<td>Starkville, MS 39760-1188</td>
</tr>
<tr>
<td></td>
<td>(662) 323-9261</td>
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<table>
<thead>
<tr>
<th>Region 8:</th>
<th>Region 8 Mental Health Services</th>
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<tbody>
<tr>
<td>Copiah, Lincoln, Madison, Rankin, Simpson</td>
<td>Dave Van, Executive Director</td>
</tr>
<tr>
<td></td>
<td>613 Marquette Road</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 88</td>
</tr>
<tr>
<td></td>
<td>Brandon, MS 39043</td>
</tr>
<tr>
<td></td>
<td>(601) 825-8800 (Service); (601) 824-0342 (Admin.)</td>
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<table>
<thead>
<tr>
<th>Region 9:</th>
<th>Jackson Mental Health Center</th>
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<tbody>
<tr>
<td>Hinds</td>
<td>Margaret L. Harris, Director</td>
</tr>
<tr>
<td></td>
<td>3450 Highway 80 West</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 7777</td>
</tr>
<tr>
<td></td>
<td>Jackson, MS 39284</td>
</tr>
<tr>
<td></td>
<td>(601) 321-2400</td>
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<table>
<thead>
<tr>
<th>Region 10:</th>
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</thead>
<tbody>
<tr>
<td>Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith</td>
<td>Maurice Kahlmus, Executive Director</td>
</tr>
<tr>
<td></td>
<td>1415 College Road</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 4378</td>
</tr>
<tr>
<td></td>
<td>Meridian, MS 39304</td>
</tr>
<tr>
<td></td>
<td>(601) 483-4821</td>
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<table>
<thead>
<tr>
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<tr>
<td>Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson</td>
<td>Steve Ellis, Ph.D., Executive Director</td>
</tr>
<tr>
<td></td>
<td>1701 White Street</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 768</td>
</tr>
<tr>
<td></td>
<td>McComb, MS 39649-0768</td>
</tr>
<tr>
<td></td>
<td>(601) 684-2173</td>
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<tr>
<th>Region 12:</th>
<th>Pine Belt Mental Healthcare Resources</th>
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<tr>
<td>Covington, Forrest, Greene, Jeff Davis, Jones, Lamar, Marion, Perry, Wayne</td>
<td>Jerry Mayo, Executive Director</td>
</tr>
<tr>
<td></td>
<td>103 South 19th Avenue</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 1030</td>
</tr>
<tr>
<td></td>
<td>Hattiesburg, MS 39403</td>
</tr>
<tr>
<td></td>
<td>(601) 544-4641</td>
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</table>
| Region 13: Hancock, Harrison, Pearl River, Stone | Gulf Coast Mental Health Center  
Jeffrey L. Bennett, Executive Director  
1600 Broad Avenue  
Gulfport, MS 39501-3603  
(228) 863-1132 |
| Region 14: George, Jackson | Singing River Services  
Sherman Blackwell, II, Executive Director  
3407 Shamrock Court  
Gautier, MS 39553  
(228) 497-0690 |
| Region 15: Warren, Yazoo | Warren-Yazoo Mental Health Services  
Steve Roark, Executive Director  
3444 Wisconsin Avenue  
P. O. Box 820691  
Vicksburg, MS 39182  
(601) 638-0031 |
ALCOHOL & DRUG ABUSE SERVICES

- Detoxification
- Primary Residential
- Transitional Residential
- Outreach/Aftercare
- Prevention
  - Prevention Services
  - SPF-SIG
- Chemical Dependency Unit
- Outpatient
  - Day Treatment
  - Intensive Outpatient
  - Outpatient Opioid Addiction
- DUI Diagnostic Assessment
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<tr>
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<th>Program</th>
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<th>Beds</th>
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<tr>
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<td>Fairland Center</td>
<td>Region I Community Mental Health Center</td>
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<tr>
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<td>Haven House</td>
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<td>Denton House CDC</td>
<td>Life Help</td>
<td>32</td>
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<tr>
<td>Columbus</td>
<td>Cady Hills &amp; The Pines</td>
<td>Community Counseling Services</td>
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<td>Harbor House of Jackson</td>
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<td>Jackson</td>
<td>Born Free</td>
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<td>McClamroch Center</td>
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<td>Clarksdale</td>
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<td>Care Center / The Ark</td>
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<tr>
<td>Location</td>
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<td>Beds</td>
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<td>Columbus</td>
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<td>McClamrooch Center</td>
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<td>Whitfield</td>
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<td>90 – Adults</td>
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**Substance Abuse Prevention and Rehabilitation/Treatment Services**

**Service System**

The DMH, Bureau of Alcohol and Drug Abuse, administers the public system of substance abuse assessment, referral, prevention, treatment and aftercare/continuing care support services for the individuals it is charged to serve. It is also responsible for establishing, maintaining, and evaluating the network of service providers, which includes state-operated facilities, regional community mental health centers, and other nonprofit community-based programs.

In accordance with these beliefs, the Bureau of Alcohol and Drug Abuse strives to achieve and/or maintain high standards through the service delivery systems across the state. Therefore, the bureau is mandated to establish standards for the state’s alcohol/drug abuse prevention, treatment, and support programs; assure compliance with these standards; effectively administer the use of available resources; advocate for and manage financial resources; develop the state’s human resources by providing training opportunities; and develop an alcohol/drug abuse data system. In order to address the problems of substance abuse, the bureau believes a successful program is based on the following philosophical tenets:

* Alcoholism and drug addiction are illnesses which are treatable and preventable.

* Effective prevention services not only decrease the need for treatment, but provide for a better quality of life.

* Substance abuse problems are prevalent in all culturally diverse subgroups of the population and in all socioeconomic categories.

* A comprehensive program for substance abuse assessment, referral, prevention, treatment and post-treatment support must be easily accessible to all culturally diverse individuals and across all socioeconomic levels.

* If appropriate, services should be delivered in a community setting.
Continuity of care is essential to an effective substance abuse treatment service program.

Vocational rehabilitation is an integral part of the recovery process.

Effective treatment and recovery include delivery of services to the individual and his/her family.

Individuals with substance abuse problems can return to a productive role within society, their local community and their families.

All substance abuse services are provided through a grant/contract with other state agencies, and/or non-profit free-standing organizations. Primarily, the network of services comprising the public system is delivered through the following avenues:

**State-operated facilities:** Two of the four state psychiatric hospitals which are operated by the Department of Mental Health, provide medically-based inpatient chemical dependency treatment and aftercare services. These facilities serve designated counties or service areas in the state. East Mississippi State Hospital provides 25 slots for adult males. The Bradley Sanders Adolescent Complex provides 10 slots for chemically dependent and co-occurring male adolescents. Chemical Dependency treatment services at Mississippi State Hospital consists of two units. One provides 51 slots for adult males who live within its service area. The second unit provides 39 slots for adult females statewide. These facilities provide services including: detoxification; individual and group counseling; family conferences/counseling; medical care; vocational counseling; educational programs targeting recovery from substance abuse, including understanding the disease of substance abuse, the recovery process, relapse prevention skills, anger management, etc. The programs also include recreational and social activities that present alternatives to continued alcohol and drug use and emphasize the positive aspects of recovery, and outreach/aftercare (continuing care) planning and implementation. The adolescent programs include accredited educational services through the MS Department of Education.

The Community Services program of the Mississippi State Hospital operates the Mental Illness with Chemical Addiction Recovery Environment (MICARE) facility. This facility is a 12 slot transitional residential facility for adult males with a dual diagnosis of mental illness and chemical addiction.

**Regional Community Mental Health Centers**
The community mental health/mental retardation centers (CMHCs) with whom DMH contracts, are the foundation and primary service providers of the public substance abuse services delivery system. Each CMHC serves a designated number of Mississippi counties. There are sixty-nine community-based “satellite centers” throughout the state which allow greater access to services by the area’s residents. The goal is for each Community Mental Health Center to have a full range of treatment options available for citizens in its region.

Substance abuse services usually include: (1) alcohol, tobacco, and other drug prevention services; (2) general out-patient treatment including individual, group, and family counseling; (3) outreach/aftercare (continuing care) support planning and implementation services; (4) primary residential treatment services (including detoxification services); (5) transitional residential treatment services; (6) vocational counseling and employment seeking assistance; (7) emergency services (including a 24-hour hotline); (8) educational programs targeting recovery from substance abuse which include understanding the disease, the recovery process, relapse prevention and anger management; (9) recreational and social activities presenting alternatives to continued alcohol and drug use and emphasizing the positive aspects of recovery; (10) 10-15 week intensive outpatient treatment programs for individuals who are in need of treatment but are still able to maintain job or school responsibilities; (11) community-based residential substance abuse treatment for adolescents; (12) specialized women's services (including day treatment and residential treatment with emphasis on outreach activities and programs for children of alcohol and drug abusers); (13) priority treatment for pregnant/parenting women; (14) services for individuals with dual diagnoses of substance abuse and serious mental illness; (15) priority substance abuse treatment services to former SSI/SSDI recipients who are disabled by their continued substance abuse; and, (16) employee assistance programs. In addition, some centers offer specialized services for particular populations such as day treatment for female prisoners.

Other Nonprofit Service Agencies/Organizations, which make up a smaller part of the service system, also receive funding through the Department of Mental Health to provide community-based services. Many of these free-standing nonprofit organizations receive additional funding from other sources such as grants from other state agencies, community service agencies, donations, etc. These agencies typically provide one or two specialized programs such as prevention services, exclusively, or one to two types of substance abuse treatment.

Process for Funding Community-Based Services

Within the Department of Mental Health, the Bureau of Alcohol and Drug Abuse is responsible for administering the fiscal resources for alcohol and drug abuse services. The authority for funding programs to provide services to persons in Mississippi with alcohol/drug abuse problems (as well as persons with mental illness and/or mental retardation) was established through state statute. Funding is provided to community service providers by the Department of Mental Health through purchase of services (POS) or grant mechanisms. Funds are allocated by the Department through a Request for Proposals and Application Review Process. Requests for Proposals (RFPs) are disseminated among service providers through the Department's Grants Management office and detail all requirements necessary for a provider to be considered for
funding. The RFP may also address any special requirements mandated by the funding source, as well as Department of Mental Health requirements for programs providing alcohol and drug abuse services.

Agencies or organizations submit proposals which address needs of substance abuse and prevention services in their local communities to the DMH for their review. The decision-making process for selection of proposals to be funded is based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health. Applications for funding of substance abuse prevention or treatment programs are reviewed by DMH Bureau of Alcohol and Drug Abuse staff, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP, (2) the applicant's provision of services’ compatibility with established priorities, and (3) availability of resources.

Sources of Funding

Sources of funding for alcohol and drug abuse prevention and treatment services are provided by both state and federal resources.

Federal Sources

Mississippi Governor's Office, MS Department of Human Services (DHS)

Social Services Block Grant (SSBG) funds are distributed in Mississippi by the Governor's Office, MS Department of Human Services (DHS). The MS Department of Mental Health receives the funds from DHS to utilize toward developmental disabilities and substance abuse primary residential treatment services.

Center for Substance Abuse Treatment

The Substance Abuse Prevention and Treatment (SAPT) Block Grant, is applied for annually by the Bureau of Alcohol and Drug Abuse. Detailed goals and objectives for addressing specific federal requirements included in the SAPT Block Grant program are included in this application. The SAPT Block Grant is the primary funding source for DMH to administer substance abuse prevention and treatment services in Mississippi. The Bureau allocates these awarded funds to its programs statewide. Funds are used to provide the following services: (1) general outpatient treatment; (2)intensive outpatient treatment; (3)primary residential treatment programs; (4) transitional residential treatment; (5) outreach/aftercare support services; (6) prevention services; (7) community-based residential substance abuse treatment for adolescents; (8) special women’s services which include day treatment and residential treatment with priority on specialized outreach activities and programs for pregnant women and women with dependent children; (9) services for individuals with a co-occurring disorder of substance abuse and serious mental illness; and, (10) priority substance abuse treatment services to former SSI/SSDI recipients who are disabled by their continued substance abuse. In administering SAPT block
Grant funds, the DMH Bureau of Alcohol and Drug Abuse maintains minimum required expenditure levels (set asides) for substance abuse services in accordance with federal regulations and guidelines.

**State Sources**

**Alcohol Tax**

In 1977 the Mississippi Legislature levied a three percent tax on alcoholic beverages, excluding beer, for the purpose of using these tax collections to match federal funding, as deemed necessary, in order to fund alcoholism treatment and rehabilitation programs. The earmarked alcohol tax is tied directly to the volume of alcoholic beverages sold in the state. Funds from the three percent alcohol tax are used to provide hospital-based inpatient chemical dependency treatment at MS State Hospital and an alcohol and drug treatment program at the MS Department of Corrections in Parchman.

**State General Funds**

State general funds are utilized to help support community-based primary residential treatment services and hospital-based inpatient chemical dependency services at the two larger state psychiatric facilities.
### Bureau of Alcohol and Drug Abuse

**Projected Expenditures for FY 2011 and 2012**

**Actual Allocations for FY 2010**

<table>
<thead>
<tr>
<th>FEDERAL</th>
<th>FUNDING SOURCE</th>
<th>Projected FY 2011</th>
<th>Projected FY 2010</th>
<th>Actual FY 2009</th>
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<td>Social Services Block Grant</td>
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<td>Juvenile Accountability Block Grant</td>
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**Total Federal**

| Projected 18,411,569 | Projected 17,341,358 | Actual 17,343,062 |

**STATE**

| Three Percent Alcohol Tax | 5,061,910 | 4,658,410 | 4,658,410 |
| State General Funds       | 403,500   | 403,500   |           |

**Total State**

| 5,061,910 | 5,061,910 | 5,061,910 |

**Grand Total**

| 23,473,479 | 22,403,268 | 22,404,972 |
Population Served By the System

State Population

Mississippi is the 31st largest state in population. The U.S. Census Bureau figures estimated Mississippi’s 2009 population at 2,951,996. Mississippi has 82 counties and 290 incorporated cities and towns. Statistics reveal that over 53% of the state’s population lives in rural areas since many of these incorporated are nevertheless rural. The Census reveals that Mississippi’s population is 60% Caucasian and 37% African American, .4% American Indian, .8% Asian and 2% Hispanics. The percentage of population under the age of 5 is reported at 7.5% and the percentage of population under the age of 18 is 26.1% and 12.8% over the age of 65. The Bureau of Alcohol and Drug Abuse targets youth 18 and under by providing prevention and treatment programs due to the increase in alcohol and drug use.

The U.S. Census Bureau indicated that in 2008, 20.8% of Mississippi families lived below the poverty level and the median household income was estimated at $37,818 compared to $52,029 nationally. High school graduates account for 72.9% of the population in the state while 16.9% hold a bachelor’s degree or higher. Mississippi is one of the best states in the U.S. to do business. In fact, Mississippi has a diverse economy with a growing footprint in industries. Small business remains the backbone of the economy. The MS Development Authority (MDA) makes it a priority to help small business owners compete successfully in the marketplace. Industrial, commercial and consumer goods are all produced in our state. Mississippi made products are shipped regularly to well over 100 countries.

Service Population

In general, activities to estimate or determine and monitor needs for substance abuse services can be divided into two categories: (1) estimation of the number of persons with alcohol and/or drug abuse problems and at risk for needing services; and (2) estimation or determination of need for specific services among persons with alcohol and/or drug abuse problems and among subgroups of the population.

To gather comprehensive information about the prevalence of alcohol and drug problems among the general population and among subgroups of the population, as well as more detailed information on service needs and demand, the Bureau of Alcohol and Drug Abuse has collected the following data through needs assessments and/or surveys.

Substance Abuse Data Collection

There is a significant number of individuals in Mississippi at any given time which need substance abuse services. The Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse can provide services to approximately 17% of the population. The Mississippi Substance Abuse Management Information System collects data regarding admissions, discharges, types of services provided and the number of individuals served.
The Mississippi Department of Education reported 538,003 youth attended public schools, 2010-2011 and 38,000 youth attended private schools according to the Mississippi Private Schools Association. These numbers do not include youth who are home-schooled, in detention centers, treatment centers or hospitals. Many of these youth are at risk for substance use/abuse and in need of treatment due to peer pressure, easy access to drugs and an increase in the advertising industry. The Department of Education is instrumental in conducting the Youth Risk Behavior Survey to gather data on middle and high school students. See paragraph below.

**Mississippi’s 2009 Youth Risk Behavior Survey**

The Mississippi YRBS measures the prevalence of behaviors that contribute to the leading causes of mortality and morbidity among youth. The YRBS is part of a larger effort to help communities promote the “resiliency” of young people by reducing high risk behaviors and increasing health behaviors. Centers for Disease control developed the survey and the MS Department of Health and the MS Department of Education conducted the survey and the MS Department of Health analyzed the data collection for the report. The YRBS was completed by students in middle school, grades 6-8 and by students in high school, grades 9-12 during the spring of 2009. The YRBS is conducted every two years.

**SmartTrack**

SmartTrack is a web-based data collection tool developed by DREAM, Inc. which provides needs assessment data related to the Center for Substance Abuse Prevention core measures. It collects data on severity of substance abuse, risk and protective factors and identification of the most pressing prevention issues. The data is collected from schools in communities throughout the state with the goal being to establish base-line data on prevalence and severity of substance abuse, as well as related behaviors and attitudes. A survey of 121,475 6th-11th grade public school students conducted during the 2009-10 school term reveals the following protective factors among MS youth. Approximately 59% of students indicated smoking marijuana regularly posed a great risk and 47.6% stated that consuming four to five alcoholic beverages per day was a great risk. Approximately 37.4% of surveyed students strongly felt that they belonged to their school compared to 7.5% that strongly disagreed. Approximately 46.4% of students stated that they never have major fights or arguments with their parent/guardian(s), while 74% indicated that they could ask their parents for help in dealing with a personal problem. Finally, 61.2% of students indicated that their parents enforce rules at home.

**Alcohol, Tobacco and Other Drug DATA**

**Alcohol Use**

The percentage of students who had at least one alcoholic beverage in the past 30 days was 23%.

The percentage of students who reported having at least one drink of beer in the past 30 days decreased from 16.1% in 2009 to 15.4% in 2010.
The percentage of students who reported having at least one drink of a wine cooler in the past 30 days decreased from 12.1% in 2009 to 9.8% in 2010.

The percentage of students who reported having at least one drink of other alcohol (liquor, wine, mixed drink, etc.) in the past 30 days was 16.1% in 2009.

The percentage of students who had their first drink of beer before age 15 was 34.5% in 2004 to 31.9% in 2009.

The percentage of students who had their first drink of a wine cooler before age 15 was 27.7% in 2004 to 21% in 2009.

The percentage of students who had their first drink of other alcohol (liquor, wine, mixed drink, etc.) in the past 30 days was 15.9% in 2010.

The percentage of students who engaged in binge drinking was 14.1% in 2010.

The percentage of students who reported drinking alcohol before the age of 13 years was 26.4% in 2009; the national average was 21.1%. (YRBS, 2009)

**Tobacco Use**

The percentage of students who reported cigarette use in the past 30 days was 19.6% based on 2009 YRBS estimates. Estimates from the 2010 Smart Track Survey showed that about 13% of grade 6-11 students used cigarettes in the past month.

The percentage of students who have used chewing tobacco or snuff during the past 30 days did not change significantly from 6.9% in 2009 to 7.1% in 2010. (SmartTrack, 2010)

The percentage who smoked a whole cigarette before age 13 was 16.6% in 2009, the national average was 10.7 %.( YRBS, 2009).

**Other Drug Use**

According to the 2010 Mississippi Smart Track Survey:

The percentage of students who used any form of cocaine including powder, crack, or freebase one or more times in the past 30 days was 2.3% in 2010.

The percentage of students who use heroin one or more times in the past 30 days was 2.3% in 2010.

The percentage of students who sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times in the past 30 days was 3.5% in 2010.

The percentage of students who used marijuana one or more times during the past 30 days increased from 8.9% in 2009 to 9.1% in 2010.
An estimated 4.9% of 6th - 11th grade students reported non-medical use of prescription drugs at least once in the past month.

The percentage of students who tried marijuana for the first time before age 13 years was 8.4% in 2009; the national average was 7.5%. (YRBS, 2009)

National Survey on Drug Use and Health (NSDUH) for Mississippi

According to statistics cited in SAMHSA’s 2007-2008 National Survey on Drug Use and Health (NSDUH) Mississippi State estimates, the percentage of persons aged 12 or older reporting use of any illicit drug other than marijuana or prescription drugs in the past month was 3.1%. The percentage of persons aged 12 or older reporting dependence on or abuse of any illicit drug was 2.4%. By age group, an estimated 3.4% of 12-17 year olds 6.7% of 18-25 year olds and 1.5% of persons age 26 or older reported dependence on or abuse of any illicit drug. Past month marijuana use among Mississippians 12 years and older was 4.4%. By age group, use among 12-17 year olds was 4.5% ; among 18-25 year olds it was 11.4%; and among persons 26 years or older it was 3.0%. Approximately 38% of Mississippians age 12 or older were past month alcohol users. By age group, an estimated 11.9% of 12-17 year olds, 48.6% of 18-25 year olds and 39.9% of persons 26 were past month alcohol users. Past month binge alcohol use among Mississippians was 19.9%. An estimated 6.3% of Mississippians age 12 or older reported dependence on or abuse of Alcohol. Rates for dependence were higher within the 18-25 year age group (14%), with 12-17 year olds and persons older than 26 reporting dependence rates 3.8% and 5.2% respectively.
**Kids Count**

Economically, the lack of a viable non-agriculture-based economy has resulted in stagnant incomes and low-skilled jobs. Hence, approximately 17% of Mississippians live below the poverty line in 2009 compared to just 13.2% of Americans nationally. According to The Annie E. Casey Foundation’s *2010 KIDS COUNT Data Book* the following conditions exist for children in MS today.

<table>
<thead>
<tr>
<th>TABLE 1—CHILD WELL-BEING INDICATORS</th>
<th>STATISTIC</th>
<th>CHANGE FROM PREVIOUS YEAR</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of children in poverty (2008)</td>
<td>18%</td>
<td>30% increased</td>
<td>50th</td>
</tr>
<tr>
<td>Teen birth rate (Births per 1,000 females ages 15-19) (2007)</td>
<td>43</td>
<td>72 increased</td>
<td>50th</td>
</tr>
<tr>
<td>Infant mortality rate (Death per 1,000 live births) (2007)</td>
<td>6.7</td>
<td>10.0 decreased</td>
<td>50th</td>
</tr>
<tr>
<td>Percent of children in single-parent households (2008)</td>
<td>32%</td>
<td>45% increased</td>
<td>50th</td>
</tr>
<tr>
<td>Percent of teens not attending school and not working (Ages16-19) (2008)</td>
<td>8%</td>
<td>9% decreased</td>
<td>34th</td>
</tr>
<tr>
<td>Percent of teens who are high school dropouts (Ages 16-19) (2008)</td>
<td>6%</td>
<td>7% decreased</td>
<td>25th</td>
</tr>
<tr>
<td>Child death rate (Deaths per 100,000 Children Ages 1-14) (2007)</td>
<td>19</td>
<td>34 increased</td>
<td>50th</td>
</tr>
<tr>
<td>Teen death rate (Deaths per 100,000 teens ages 15-19) (2007)</td>
<td>62</td>
<td>98 increased</td>
<td>49th</td>
</tr>
<tr>
<td>Overall child well-being (2008)</td>
<td>50th</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mississippi HIV/AIDS Data**

The MS Department of Health, Bureau of STD/HIV reported that in 2010 there were 550 newly diagnosed cases of HIV disease. Persons living with HIV/AIDS in Mississippi in 2010 totaled 9,546. There are currently 6,927 African Americans who are living with HIV. This is particularly important to note since they represent only 37% of Mississippi’s general population. There are currently 2,248 Caucasians who are living with HIV. Out of the nine Public Health Districts, the top five counties in 2010 which had persons diagnosed with HIV disease were: Hinds (137), Harrison (37), DeSoto (30), Rankin (29) and Forrest (26).
Substance Abuse System Model

The Mississippi Substance Abuse System Model incorporates and reflects commitment to the mission, vision, core values and guiding principles of the agency. Individuals receiving appropriate services, each with his or her individual strengths and needs, is the essence of the model. Central to the comprehensive public mental health service system is the belief that individuals are most effectively treated in their community and close to their homes, personal resources and natural support systems.

The development of the model reflects integration of services to meet individual needs and to facilitate accessibility and continuity of care. In meeting individual needs throughout the system, emphasis is placed on preserving individual dignity and rights including privacy and confidentiality, in the most culturally appropriate manner.

The state’s vision for a statewide person-driven, family-centered system of care emphasizes the importance of access and coordination with other service agencies. System-wide support services may include operational services that may be provided through a variety of other agencies or entities. Inherent in the Substance Abuse System Model are the characteristics of consistency, accountability and flexibility to allow responsiveness to changing needs and service environments.
Substance Abuse System Model

Person - Centered

Prevention Services
Health Services
Recovery Supports
Vocational Services
Treatment Services

Substance Abuse

Mental Health Services
Social Services
Juvenile Justice Services

Comprehensive Services

Community - Based
The components of the alcohol and drug abuse prevention and treatment service system are aligned with the Department of Mental Health’s Strategic Plan. The components encompass the strategic plan’s nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training and information management.

**Substance Abuse Prevention Services**

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco and other drug abuse. Based on identified risk and ‘protective’ factors, these activities must be carried out in an intentional, comprehensive, and systematic way in order to impact large numbers of people.

Most substance abuse prevention programs today are targeted at youth; however, the prevalence of alcohol and drug use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use determine, to a large extent, the environment in which choices will be made about use by children and adolescents. Therefore, the Bureau of Alcohol and Drug Abuse supports prevention services that target adults as well as young people.

The causes of substance abuse are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and media messages often promote or convey acceptance of drug abuse behaviors. All of these factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance abuse. Prevention strategies have been categorized in a variety of different ways. The Bureau of Alcohol and Drug Abuse requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental. (The definition of each strategy may be found in the *Federal Register*, Volume 58, Number 60, March 31, 1993).
Through the Bureau of Alcohol and Drug Abuse, Mississippi has made great strides in improving the prevention delivery service system during the past five years. BADA has instituted many new policies for subgrantees funded by the 20 percent prevention set aside of the SAPT Block Grant. Two examples include: 1) designation of an individual to coordinate prevention services and 2) requiring each program to implement at least one evidence-based program. The State Incentive Grant (SIG) awarded to BADA in 2001 allowed BADA to fund addition programs utilizing evidence-based programs and more than doubling the amount of individuals and families served. In October 2006, BADA received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals: (1) Build prevention capacity and infrastructure at state and community levels; (2) prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; and (3) Reduce substance abuse-related problems in communities.

The Bureau of Alcohol and Drug Abuse serves as the state Regional Alcohol and Drug Awareness Resource (RADAR). Six of the thirty DMH funded prevention programs serve as RADAR network centers. These centers maintain and provide access to a collection of substance abuse resources for reference and circulation through support for the National Clearinghouse for Alcohol and Drug Information located in Maryland.

Substance Abuse Rehabilitation/Treatment Services

Treatment Modalities

The Bureau of Alcohol and Drug Abuse encourages “Best Practices” that aim to investigate the potential problem of substance abuse and motivate the individual to do something about it either by natural, client-directed means or by seeking additional substance abuse treatment. This can be done by utilizing brief interventions in an outpatient setting which is the most common modality of substance abuse treatment. If the individual needs a more intense level of treatment, a residential setting is recommended. Some evidence-based practices currently being utilized in treatment are brief interventions, cognitive-behavioral therapy, group-based approach therapy, 12 step facilitation therapy and motivational interviewing.

Family Support

For many individuals with substance abuse disorders, interaction with their family is vital to the recovery process. The family has a central role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the abuser relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access and knowledge of the referral and placement process.
Access to Community-Based Primary Residential Services

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

Primary residential treatment’s group living environment offers clients access to a comprehensive program of services that is easily accessible and immediately responsive to each client’s individual needs. Because alcohol and drug dependency is a multidimensional problem, various treatment modalities are available, including detoxification, group and individual therapy; family therapy; education/information services explaining alcohol/drug abuse and dependency; personal growth/self help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and, recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process and is designed to meet the specific needs of each client.

Although all substance abuse treatment programs are accessible to pregnant women, there are two, described in the following paragraph, that are specifically designed for this population. Additionally, there are primary residential treatment programs tailored for adolescents and for prisoners. These are described below:

Specialized Primary Residential Services for Pregnant Women and Women with Dependent Children: In addition to traditional treatment modalities described above, these programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

Specialized Primary Residential Services for Adolescents: While providing many of the same therapeutic, informational/educational, social/recreational services as adult programs, the content is modified to accommodate the substance abusing adolescent population. Adolescent treatment programs are generally longer in duration than adult primary residential programs. Some allow the client to remain from six months up to as long as a year, depending on several factors that may include the program’s recommendations, parental participation, and the client’s progress and adaptability. Also, all programs provide regularly scheduled academic classes individually designed for each client following a MS Department of Education approved curriculum by an MDE certified teacher.
Specialized Services for Prisoners: Substance abuse screening and a primary treatment unit are provided for the inmates at the Mississippi Correctional Facility in Parchman.

Access to Community-Based Transitional Residential Services

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

Intended to be an intermediate stage between primary treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive, fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid the client in the pursuit and acquisition of vocational, employment and/or related activities. Although all substance abuse treatment programs are accessible to pregnant women, there are two, described in the following paragraph, that are specifically designed for this population. There are also programs that provide services for female ex-offenders and dually diagnosed adult males. They are described below.

Specialized Transitional Residential Services for Pregnant Women and Women with Dependent Children: These programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. In addition to traditional therapeutic activities, the treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

Specialized Transitional Residential Services for Female Ex-offenders: This program provides immediate support for women leaving primary substance abuse treatment programs in correctional facilities. Priority is given to pregnant women and plans are currently underway for this program to include parenting women, where their children are housed with them.

Specialized Transitional Residential Services for Co-occurring Adult Males: This program is designed to address both the individual’s chemical dependency and mental illness. These individuals, primarily from the Mississippi State Hospital population, are ready to leave the hospital environment but still require a supported living environment. Treatment is provided in a group living environment which promotes a life free from chemical dependency and provides appropriate support for the client’s mental illness. BADA contracts with Mississippi State Hospital (MSH), Bureau of Community Services to provide this service.
Access to Community-Based Outpatient Services

Each program providing alcohol and drug abuse outpatient services must provide multiple treatment modalities, techniques and strategies which include individual, group, and family counseling. Program staff must include professionals representing multiple disciplines who have clinical training and experience specifically pertaining to the provision of alcohol and drug abuse services.

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

**General Outpatient Services for Opiate Addiction**: The Bureau of Alcohol and Drug Abuse in collaboration with the Center for Substance Abuse Treatment (CSAT) continues its relationship in addressing issues of treatment for individuals who are addicted to prescription pain medications and patients who are addicted to heroin and other opiates. The State Methadone Authority (SMA) works closely with the State’s opiate replacement program to promote programs which stress the core values of opiate treatment including the right of the individual to be treated with dignity and respect.

The Bureau of Alcohol and Drug Abuse is becoming more focused on the need to increase awareness of treatment for opiate addiction as well as educate community members and its leaders. Also, the Commission on Accreditation of Rehabilitation Facilities (CARF) is a certifying body which serves as a catalyst for improving the quality of life of individuals in opiate treatment facilities. This mission coupled with the State Standards provides the best possible optimal care. Currently, the State has one certified treatment program located in Jackson. As resources become available, additional programs will be established.

**General Outpatient Services for Co-occurring Disorders**: In addition to the funding provided by the Bureau of Alcohol and Drug Abuse to community-based transitional residential programs, mentioned earlier, the Bureau also allocates funds specifically earmarked for services for Co-occurring Disorders through each regional community mental health center. The Bureau of Alcohol and Drug Abuse collaborates with the Bureau of Community Mental Health Services by providing joint co-occurring disorders training throughout the state. Both bureaus work together in preparation of the trainings and the selection of the trainers.

**Intensive Outpatient Program (IOP) for Adults**: This program provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance abuse problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the
client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each group member at least once per week.

**Specialized Intensive Outpatient Services for Adolescents:** These programs operate in the same manner as those described above, but focus on the special needs of adolescents. The program allows the young person to maintain responsibilities related to education, family, employment and community while receiving treatment.

**Specialized Day Treatment Services for Women:** This community program typically involves group therapy that is offered for a minimum of four hours per day from three to four days per week to women. It is operated by a DMH-funded/certified free-standing substance abuse treatment program.

**Specialized Day Treatment Services for Female Inmates:** This program typically involves group therapy that is offered for a minimum of four hours per day from three to four days per week to the female inmates at a local correctional facility. It is operated by a DMH-funded/certified free-standing substance abuse treatment program.

**Access to Hospital-Based Inpatient Chemical Dependency Unit Services**

Inpatient or hospital-based facilities offer treatment and rehabilitation services for individuals whose substance abuse problems require a medically monitored environment. These may include: (a) patients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting; (b) patients with withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes detoxification, assessment and evaluation, intervention counseling, aftercare, a family support program and referral services.

Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance abuse. The program is designed to break the cycle of being frequently hospitalized by treating the substance abuse simultaneously with the mental illness.
Substance Abuse Therapeutic Support Services

Access to Community-Based Aftercare/Outreach Services

Aftercare services are designed to assist individuals in maintaining sobriety. It is a bridge between active treatment and long-term recovery. Initiated at the beginning of the treatment process, aftercare is designed for clients who have completed primary substance abuse treatment. Aftercare provides structured support and assistance to the client through formal regularly scheduled meetings and individual sessions, as needed. The group meeting usually facilitated by program staff, allows the members to offer encouragement and support to each other in maintaining sobriety. Aftercare program personnel also assist in making referrals, securing additional needed services from community mental health centers or from other health or human services providers, while maintaining contact and involvement with the client's family.

Outreach services assist persons with substance abuse problems and/or their families by providing information on, encouraging utilization of, and providing access to needed treatment or support services in the community. Outreach activities may include speaking engagements to community groups about substance abuse services and/or visiting local courts and jails to inform and access available services for offenders.

Outreach Services/Older Adult

Outreach services are provided to the older adult with substance abuse issues and/or their families by providing information and access to needed treatment. Alcohol and prescription drug misuse and abuse are prevalent among older adults due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. Alcohol abuse and drug dependence are directly correlated with other potential causes of cognitive impairment. Coupled with drug abuse and cognitive impairment, they should be encouraged to seek appropriate treatment. Counselors often use the opportunity to educate the older adult and to help them to acknowledge their addiction. Patient understanding and cooperation for the older adult are essential in eliciting accurate information in order to carry out the appropriate type of treatment. Depending on the individual’s particular situation, the person’s needs may change over time and require different levels and intensities of rehabilitation.

DUI Diagnostic Assessment Services

The DUI (Driving Under the Influence) Diagnostic Assessment Services are for individuals who have been convicted of two or more DUI violations which have resulted in the suspension of their driver’s license. The diagnostic assessment process was first developed and sanctioned through the Mississippi Implied Consent Law by our State Legislature to encourage alcohol and drug treatment and to reduce the suspension period for offenders. During the 2007 Legislative Session, the Implied Consent Law was
amended requiring first offenders’ license suspension to be no less than 90 days and to enroll and complete the Mississippi Alcohol Safety Education Program (MASEP) before their license can be reinstated.

The diagnostic assessment process ensures the following steps are taken. First, an approved DMH diagnostic assessment instrument is administered. Secondly, the results of the assessment is evaluated as well as the client intake assessment. Thirdly, the BAC (Blood Alcohol Content) report and the motor vehicle record are reviewed and fourthly, collateral contacts and if appropriate other clinical observations are recorded. If treatment is warranted after the completion of the process, the offender is placed in an appropriate treatment setting.

There were 9,665 adult DUI arrests in 2010. There were 841 DUI arrests made to individuals under the age of twenty-one (21). The Mississippi underage driver accounts for 7.9% of all Mississippi drivers arrested for DUI. The most alarming fact is that these young drivers are committing two serious offenses – both drinking illegally and then driving under the influence. The average (mean) BAC (Blood Alcohol Content) for all DUI arrests during 2010 was .138. This is evidently well above the BAC of .08 and .02 for under age twenty-one (21). The impaired driver is the primary contributing factor in fatal traffic crashes every year. The fines assessed for DUI are above 7 million dollars annually. The alcohol traffic safety indicators did show a positive change during 2010. The “Over the Limit – Under Arrest” public information and education campaign coupled with strict enforcement showed significant progress in reducing deaths on our roadways. The impaired driver shows that when DUI arrests increase, there is an inevitable decrease in both total traffic deaths and alcohol related deaths.

Mississippi Drug Courts

Mississippi currently has 39 drug courts covering 63 of the 82 counties. There are 23 adult programs, 14 juvenile programs and 2 family drug court pilot programs. The mission of the drug courts is to establish a system with judicial requirements which will effectively reduce crime by positively impacting the lives of substance abusers and their families. The target population of the program is for first time non-violent offenders, age 18. An evaluation process determines whether or not an offender is eligible for the program. During 2010 there were 2,817 individuals enrolled in drug courts statewide. There were 423 individuals who were graduates of the program. In that same year, participants paid $768,064 in fines to the counties and $964,077 in fees to the drug courts.

Senate Bill 2246 which becomes effective July 1, 2008 states that the State Drug Court Advisory Committee “shall establish through rules and regulations a viable and fiscally responsible plan to expand the number of adult and juvenile drug court programs operating in Mississippi. These rules and regulations shall include plans to increase participation in existing and future programs while maintaining their voluntary nature.”
Currently, the Bureau of Alcohol and Drug Abuse allocates funding support for a private, non-profit free standing community-based program, IQOL (Improving Quality of Life) to implement the ICMS’s (Intensive Case Management Services) phase of the Drug Court Program. The case managers work closely with the court system to assist the client in meeting the judicial requirements administered by the court. Clients are offered the incentive of a chance to remain out of jail and the sanction of a jail sentence if they fail to remain drug-free and noncompliant. The director of the Bureau of Alcohol and Drug Abuse serves on the State Drug Courts Advisory Committee which meets monthly.

**Vocational Rehabilitation Services**

Each primary residential treatment program provides vocational counseling to individuals while they are in the treatment program. In transitional treatment the primary focus is assisting the client, if needed, in securing employment and/or maintaining employment. The Department of Rehabilitation Services, Office of Vocational Rehabilitation partners with the Bureau of Alcohol and Drug Abuse in providing some monetary support for eligible individuals in the transitional residential treatment programs.

**Tuberculosis and HIV/AIDS Assessment/Educational Services**

All individuals receiving substance abuse treatment services are assessed for the risk of tuberculosis and HIV/AIDS. If the results of the assessment indicate the individual to be at high risk for infection, they are referred for additional testing. Individuals also receive educational information regarding HIV/AIDS, STDs, TB and MS Implied Consent Law either in individual or group sessions during the course of treatment.

**Referral Services**

For many years the Bureau of Alcohol and Drug Abuse has published the Mississippi Substance Abuse Prevention and Treatment Resources Directory in order for the public to access substance abuse services. The directory is comprised of all DMH certified substance abuse treatment and prevention programs as well as other recognized programs across the state of Mississippi. It is revised, updated and redistributed by the BADA every two years. The current publication, 2011-2012 has been distributed to treatment facilities, human services organizations, and a wide variety of other interested parties statewide. The manual is extensively used for a variety of referral purposes. In addition, individuals seeking referral information through the Department of Mental Health may do so by contacting a toll-free help line, operated by the DMH Office of Constituency Services. In 2011, approximately 2000 copies have been distributed throughout the United States.
Other Substance Abuse Prevention and Rehabilitation/Treatment Support Services

Linkages/Partnerships with Other Service Systems

Staff from the Bureau of Alcohol and Drug Abuse actively participate in and/or serve on numerous interagency committees, task forces, and other entities dedicated to the continuous development and maintenance of appropriate, accessible substance abuse prevention and treatment services. The Bureau’s Prevention Director and Coordinator continue to be a member of the Mississippi Executive Prevention Council (MEPC). The MEPC, coordinated by DREAM, is an interagency committee that facilitates communication among local and state agencies/entities involved in substance abuse prevention services and support. The Division continues to work in collaboration with the Attorney General’s Office in enforcement of the state statute prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner. Representatives from the Department of Mental Health participate on The State Tobacco Control Advisory Council. This Council is comprised of a variety of state and private agencies whose mission is to achieve a comprehensive approach to tobacco control involving prevention and cessation services. The DMH Bureau of Alcohol and Drug Abuse continues its contract with the Department of Rehabilitation Services (Office of Vocational Rehabilitation) to fund substance abuse treatment services to individuals in transitional residential programs. The Bureau continues to contract with Mississippi State Hospital (MSH), Bureau of Community Services to support one transitional residential facility for the treatment of individuals with co-occurring disorders (substance abuse and mental illness). Staff from the Bureau actively participate on the Co-Occurring Disorder Coordinating Committee. The Coordinator of DMH’s Employee Assistance Program is a member of the Employee Assistance Professional Association which facilitates communication between public and private EAP providers throughout the state. A Bureau staff member serves on The MS Community Planning Group for HIV Prevention, a diverse body of individuals representative of various HIV- and STD-affected communities in the state. This group coordinated by the MS Department of Health functions to foster the principles of HIV prevention community planning and to develop an annual Comprehensive HIV Prevention Plan for Mississippi. Bureau staff also serve on the Mississippi Association of Highway Safety Leaders, a group whose overall mission is to reduce deaths and serious injuries on Mississippi roadways though public education; increase enforcement of highway safety laws; progressive legislation and support of national and state transportation policies and programs. The DMH, Bureau of Alcohol and Drug Abuse and the Department of Human Services (DHS), and several regional community mental health centers began a collaborative effort to determine the need for and access to substance abuse services for individuals who receive services through the DHS’s Mississippi Recipients of Temporary Assistance for Needy Families (TANF) program. A second objective is to determine a possible correlation between substance abuse and domestic violence. Several of the DMH staff are members of the Mississippi Chapter of the National Coalition Building Institute.
(NCBI), a non-profit organization founded in 1984 in an effort to eliminate prejudice and reduce intergroup polarization. Having worked closely with NCBI, the Department decided to establish a Multicultural Task Force and it is currently active. The mission of the task force is to address issues relevant to providing mental health services to minority populations in Mississippi and make recommendations to the State Mental Health Planning Council. The Bureau is represented on this task force which has provided training to increase the awareness and sensitivity of different cultures. This includes an annual Day of Diversity which focuses on embracing the diversity of individuals. Many of the DMH service providers have begun to sponsor this day in their own communities.

BADA works closely with the Mississippi Association of Addiction Professionals (MAAP) which is the certifying body for alcohol and drug counselors. Additionally, a Bureau staff member serves on the Board of Directors of the Mississippi Alliance for School Health (MASH) which is a non-profit organization dedicated to promoting and encouraging the use of the Centers for Disease Control and Prevention’s components of a coordinated school health program (CSHP). The Bureau’s Prevention Director serves on the Advisory Council for the Mississippi Council on Problem and Compulsive Gambling. The Director of the Bureau of Alcohol and Drug Abuse serves on the State Drug Courts Advisory Committee which meets monthly.

Inter-Bureau Collaboration

The Bureau of Alcohol and Drug Abuse collaborates with all seven bureaus in the Department of Mental Health. Inter-bureau collaboration is a vital component in carrying out the responsibilities and duties of the Department. BADA works closely with the following areas: Human Resources, Staff Development and Training, Certification and Licensure, Grants Management, Purchasing, and Referral and Placement.

Workforce Development

The DMH Bureau of Alcohol/Drug Abuse provides regularly scheduled, ongoing training/technical assistance to substance abuse treatment and prevention service providers. The purpose is to teach, maintain, and improve treatment and prevention skills/techniques in order to assure optimum quality, state of the art services to clients. Additionally, all DMH funded/certified programs must provide training that meets the staff development requirements outlined in the Operational Standards for Community Mental Health/Intellectual and Developmental Disabilities Services. The Bureau of Alcohol and Drug Abuse also provides funds to help support the attendance of the staff of community services providers at other training/continuing education opportunities.

Bureau of Alcohol and Drug Abuse Advisory Council

An important mechanism for public input is the Mississippi Alcohol and Drug Abuse Advisory Council. The Council advises and supports the Bureau of Alcohol and Drug Abuse, promotes and assists in developing effective prevention programs, and promotes the further development of alcohol and drug treatment programs at the community level.
Specific activities of the Council include the following: providing input into the development of the annual State Plan for Alcohol and Drug Abuse Services; participating in the Department of Mental Health’s peer review process; and, participating on various committees, conferences, and meetings related to the prevention and treatment of substance abuse. The Council also supports the Bureau of Alcohol and Drug Abuse as staff carries out its duties to ensure that substance abuse services are provided to those individuals in need. The Council members represent a broad range of geographic, ethnic, and socio-economic backgrounds. The Council meets quarterly and may hold other meetings upon requests.

Substance Abuse Prevention and Treatment Quality Assurance Services

Accountability – Certification and Monitoring

The Division of Accreditation and Licensure within the Bureau of Community Services, is responsible for the coordination and development of the Operational Standards for Community Mental Health/Intellectual and Developmental Disabilities Services for community programs that receive funds through the authority of the Department of Mental Health. Representatives from all human services Bureaus and Divisions, including the Bureau of Alcohol and Drug Abuse participate in this ongoing accountability process of review, monitoring and certification during on-site visits to determine continued compliance with the service delivery or client-related requirements in the Operational Standards. Monitoring includes the review and evaluation of each specific service area as well as case record management and client records, environmental and safety requirements, clients' rights, and confidentiality policies and procedures.

Peer Review

The DMH, including the Bureau of Alcohol and Drug Abuse, has developed a peer review process for the purpose of determining if a provider is meeting the Council on Quality and leadership’s (CQL) 21 Personal Outcome Measures (POM) in the provider’s provision of targeted services. Peer Review visits take place with a provider 2-4 weeks before a DMH Certification Visit. Members of the Peer Review Team conduct personal interviews with individuals who are receiving services to determine the presence of the 21 Personal Outcome Measures in the individual’s life. Interviews are based on a standardized instrument developed by CQL and administered by peers who have been trained in administering the survey. Peers also conduct personal interviews with support staff to compare the information provided by individuals to determine the types of services/supports provided that support the 21 Personal Outcome Measures. The Peer Review Team Leader compiles all of the interviews into a final report which is included in the provider’s Written Report of Findings from the DMH site/program visit. At the end of the peer review visit, the team leader will give the provider an overview of the findings. The report is then distributed to the DMH staff pre-visit meeting to review the findings and a copy of the report is sent to the DMH Clinical Services Liaison for review. The
Clinical Services Liaison will review the results and areas of concern (<85% outcome) and if needed, technical assistance will be offered by DMH.

**Consumer Grievances and Complaints**

The Office of Constituency Services receives, investigates, and resolves consumer complaints and reports of serious incidents in all programs and services operated and/or certified by the Department of Mental Health. Consumer complaints and serious incident reports are logged into a computer system for reporting purposes but are followed through on paper to protect the confidentiality of the consumer. During 2010 – 2011, OCS received approximately 2,671 calls associated with alcohol and drug abuse.

**Performance/Outcome Measures**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is interested in demonstrating program accountability and efficacy for prevention and treatment programs through the National Outcome Measures (NOMs). The NOMS are intended to document the performance of federally supported programs and systems of care. The Bureau of Alcohol and Drug Abuse has established a data infrastructure for the purpose of capturing data and reporting performance indicators for alcohol and drug prevention and treatment services. Compliance is maintained by the Bureau regarding the performance of these measures.

**Mississippi Substance Abuse Management Information System (MSAMIS)**

This system was developed to provide current information on consumers and the treatment provided to them in order to aid in the planning, management and evaluation of substance abuse treatment programs. The Bureau of Alcohol and Drug Abuse provides an instruction manual for utilization of the MSAMIS to the service providers. The manual includes data definitions and requirements for the collection and transmission of all data items pertaining to clients. The Department of Mental Health, Division of Information Systems works closely with BADA collecting data regarding services from the alcohol and drug abuse free-standing, nonprofit providers.

All data (hard copies, diskettes and CDs) received by the Bureau of Alcohol and Drug Abuse is reviewed for quality assurance by a staff member and the information from the hard copies is entered into the central system. The data from the diskettes or CDs is submitted to the Division of Information Systems. Also, the DMH is in the process of integrating federal minimum data sets for alcohol (Treatment Episode Data Set {TEDS}) and mental health services within a statewide information management system. TEDS contains information on substance abuse treatment admissions that is routinely collected by States in monitoring substance abuse treatment programs. Data items for each admission include demographic information, substances of abuse, and information on prior treatment episodes and the treatment plan. TEDS now includes a discharge data set.
as well. Implementation of the statewide information management system is ongoing. The Bureau of Alcohol and Drug Abuse continues to collaborate with the DMH, Division of Information Systems, in order to improve the quality and expediency of substance abuse data collection.

**Employee Assistance Programs Services**

An employee assistance program (EAP) is a worksite-based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: family, marital, health, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect employee job performance. The Department of Mental Health, Bureau of Alcohol and Drug Abuse provides information and technical assistance to other state agencies and organizations interested in planning or developing employee assistance programs.

Specific objectives include: (1) assisting other agencies and organizations in planning and developing an EAP and providing guidance throughout the process, as requested; (2) working as an advocate for EAP services and with community organizations, agencies, and institutions to solicit participation in EAPs so the adequate resources are available for proper delivery of services to program participants; and (3) working with agency management and other administration officials to coordinate EAP activities and to resolve problems or issues that impair the effectiveness and efficiency of the program.

The Department of Mental Health Employee Assistance Program Handbook has been updated and distributed to organizations and agencies upon requests. DMH contracts with The Counseling Center in Ridgeland, MS to provide EAP services for mental health employees and their families. The Mental Health EAP coordinator works closely with the counseling staff to ensure the needs of the Department’s employees and their families are met. The EAP coordinator also provides training and technical assistance to local and state entities who are interested in developing a program.
State Priority #1: Integration of Behavioral Health and Primary Care Services

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

The FY 2012-2013 State Plans for Community Mental Health and Alcohol and Drug Abuse reflect the elements in the Department of Mental Health’s Ten-Year Strategic Plan which encompasses Integration of Behavioral Health and Primary Care Services, Recovery Supports and Provision of Services for Individuals with Co-Occurring Disorders.

Strategies designed to facilitate integration of mental illness and substance abuse are included the Department’s Plan (objectives to increase integration of primary and mental health care and to increase effectiveness of collaboration among community mental health providers, state agencies, governmental entities and non-governmental entities). The DMH intends to build on a
collaborative initiative with the Mississippi Primary Health Care Association (MPHCA) the Division of Medicaid, the regional community mental health centers and the community health centers, which grew from a 2000 Mental Health and Behavioral Health Regional Summit, sponsored by SAMHSA and HRSA. The Department of Mental Health and Mississippi Primary Healthcare Association have recently had a preliminary discussion regarding re-establishing a structured collaborative effort and inviting partner agencies, such as the Division of Medicaid, the Mississippi State Department of Health, the Department of Human Services and the University of Mississippi Medical Center, to promote communication among specialty system providers and primary care providers. Collaborative efforts will include assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise and the needs of the population for primary and specialty care. Dr. Lydia Weisser, the Department of Mental Health Medical Director, serves as the DMH "content expert” on primary care and behavioral health integration.

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

- DMH participated on the Mississippi Association of Pediatrics Task Force which developed a website that includes a standard referral process for pediatricians to use when referring children to the mental health system.
- A representative from Mississippi State Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) teams across the state.
- As part of their application to DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The community mental health centers maintain a list of resources to provide medical/dental services.
- The telepsychiatry project being implemented with funding from the Delta Health Alliance by the University of Mississippi Medical Center (UMMC) Department of Psychiatry in 18 counties in the Delta includes plans to utilize mobile technology to integrate basic medical screening into the mental health setting. Plans also include integration of mental health services in a medical setting in at least one site as part of the Delta project.
- The DMH Division of Consumer and Family Affairs is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers.
• The DMH Division of Alzheimer’s Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.
• The DMH Bureau of Alcohol and Drug Abuse continues to work with the Attorney General’s Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner.
• The DMH Bureau of Alcohol and Drug Abuse partners with the MS Department of Rehabilitation Services to fund substance abuse treatment services to individuals in transitional residential programs.
• The DMH Bureau of Alcohol and Drug Abuse works collaboratively with the MS Band of Choctaw Indians and continues to fund prevention services with Choctaw Behavioral Health.

Priority Area #1: Integration of Behavioral Health and Primary Health Care Services (Combined-SMHA/SSA)

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

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

Performance Indicator: List of PHPs in Mississippi for dissemination; Number of modifications in provider policies and procedures; monthly service reports; meeting minutes and attendance sheets; explore evidence-based practice (EBP) models related to successful integration; documentation of collaboration via grant planning meetings to acquire funding; receipt of funding opportunities awarded to promote integration; development of a plan to integrate behavioral health and primary care services; number of MOUs developed with PHPs
Priority Area #1: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

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

Strategy: Through a collaborative effort with University of Mississippi Medical Center Child Development Center (UMMCCDC), the DMH Operational Standards require children ages birth to age eighteen (18) be screened within six (6) months of Intake to determine the need for a FASD diagnostic evaluation for identification of primary health and behavioral health problems, and for intervention and treatment by behavioral and primary care providers in the local community. Local MAP Team Coordinators will coordinate the FASD screenings, referring children for diagnosis, and coordinating the provision of services. Case Managers at CMHCs implement interventions identified and assist in accessing needed primary care and behavioral health services.

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

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

Priority Area #1: Integration of Behavioral Health and Primary Care Services (Combined-SMHA/SSA)

Goal: To educate PHPs, consumers, family members, mental health/substance abuse providers and other workforce professionals on: 1) current issues and trends in alcohol, tobacco and other drug abuse (ATOD) prevention and 2) physical health topics affecting those with SMI, addiction and/or individuals with SMI and a co-occurring substance use disorder, and suicide prevention
Strategy: Increase staff, consumers and their families understanding of health related topics and the connection between physical and behavioral health; the DMH Bureaus/Divisions will partner with PHPs to plan resource /health fairs; DMH will use web, print, social media, public appearances, and the press to reach the general public, PHPs, mental health and substance abuse providers and other stakeholders in culturally and linguistically appropriate ways; DMH Bureaus and Divisions will provide substance abuse prevention and suicide prevention materials and resources to the MS Choctaw Tribal Schools in grades 7-12 on a quarterly basis; and the Bureau of Alcohol and Drug Abuse will educate PHPs on the prevention of ATOD

Performance Indicator: Educational materials disseminated to PHPs will be tracked; list of MH/SA trainings/participation by PHPs; list of PHP trainings/participation by MH/SA providers; summary of meetings and conferences provided by prevention and mental health staff; and quarterly distribution of materials and resources

Description of Collecting and Measuring Changes in Performance Indicator: Documentation of materials and dates provided will be tracked. All resources and materials uploaded to the DMH website will be updated and tracked.

Priority Area #1: Integration of Behavioral Health and Primary Care Services (SSA)

Goal: With an emphasis on primary prevention, enhance Mississippi’s capacity to bolster emotional health while preventing, delaying and mitigating symptoms and complications associated with the co-occurrence of substance abuse and mental illness.

Strategy: Generate a Capacity-Building/Infrastructure Enhancement Plan; generate a five-year Strategic Prevention Plan; add validated measures of self-reported mental health status to the student survey to discern associations between youth drug use and mental health status; create a statewide registry of evidence-based prevention and braided programs suitable for use in Mississippi, with the identification of programs suited for highly vulnerable populations and co-occurring risks.

Performance Indicator: Development of the Capacity-Building/Infrastructure Enhancement Plan and the five-year Strategic prevention Plan; addition of the mental health status measure to the student survey; creation and publication of statewide registry of evidence-based braided programs

Description of Collecting and Measuring Changes in Performance Indicator: Written documentation of the completion of the two plan proposed; evaluate results of the results measures added to the student surveys including demographic trends identified by cross tabulation; increase in utilization of evidence-based braided programs
Priority Area #1: Integration of Behavioral Health and Primary Care Services (SSA)

Goal: Enhance Mississippi’s capacity to prevent suicides and attempted suicides among populations at risk, with emphasis on military families, sexual minority (LGBTQ) youth and Native Americans.

Strategy: Add series of indicators to student school survey to examine links between drug use (previously surveyed), suicide risk, military family status, sexual minority identification and Native American background; utilize an existing advisory council (Executive Prevention Committee) to serve as the Advisory Council for the Suicide Prevention Grant (made application); develop process and support system with Mississippi Band of Choctaw Indians (MBCI) to determine co-occurring risks for Choctaw youth and adults, as well as strategies to address risks.

Performance Indicator: Development and other suicide related indicators added to the student school surveys; evaluation and dissemination of results of the survey items; documentation of serving as the Advisory Council for the Suicide Prevention Grant (made application) in minutes of the Executive Prevention Committee and development of process and support system with the MBCI.

Description of Collecting and Measuring Changes in Performance Indicator: Development and addition of indicators; evaluation of survey results of suicide related student survey items; review minutes of the Executive Prevention Committee for documentation for evidence of serving as the Advisory Council for the Suicide Prevention Grant (made application); review documentation of process and support system established with MBCI and review process data documentation of strategies to address risk.

State Priority #2: Recovery Supports

Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

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

Priority Area #2: Recovery Supports (Combined – SMHA/SSA)

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

Strategy: DMH will continue to refine the peer review/quality assurance process for all community mental health programs and services, including substance abuse services, by utilizing the Personal Outcome Measures (POM) interview protocol to measure outcomes of individuals receiving services. Consumer and family member meaningful involvement will be present on all levels of decision-making in policy development, planning, oversight, and evaluation.

Performance Indicator: Improved access and outcomes of services to individuals receiving services will be reported; Number of consumers and family members involved in decision-making activities, peer review/site visits

Description of Collecting and Measuring Changes in Performance Indicator:
DMH data

Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

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

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

Performance Indicator: Number of family education groups and number of family workshops and training opportunities to be provided; number of consumers/family members completing the MLA; list of MH/SA trainings/participation; summary of meetings and conferences provided by prevention and mental health staff; quarterly distribution of materials and resources will be tracked; and use and satisfaction of website services will be tracked.
Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

Goal: Establish statewide Medicaid reimbursement for Certified Peer Specialist services.

Strategy: DMH Bureaus and Divisions will hold quarterly meetings with the Division of Medicaid to assess and address current and future Medicaid financing structure for peer and family partner providers.

Performance Indicator: The Certified Peer Specialist service will be reimbursable by Medicaid and increase in workforce.

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

Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

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

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

Performance Indicator: DMH will utilize the Council on Quality and Leadership’s (CQL) Personal Outcome Measures (POM) tool to gain information about the level at which service providers are supporting personal outcomes of individuals being served. Increased number of consumers and family members involved in decision-making activities, peer review/site visits.

Description of Collecting and Measuring Changes in Performance Indicator:
Policies and procedures and number of POM interviews conducted by consumers and family members will be tracked.
Priority Area #2: Recovery Supports (Combined-SMHA/SSA)

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

Strategy: Continue to support and fund the development of youth support and leadership teams in CMHC Regions 4 and 7.

Performance Indicator: A regular schedule and agenda of the meetings will be available during the year for CMHC Regions 4 and 7.

Description of Collecting and Measuring Changes in Performance Indicator: The schedules and agenda are provided by the local project coordinators.

State Priority #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders

The Bureau of Alcohol and Drug Abuse and the Bureau of Community Services have an ongoing collaboration to continue to provide treatment services in both mental illness and substance abuse throughout the state. Representation from both bureaus as well as individuals from the 15 community mental health centers serve on the Co-Occurring Disorders Coordinating Committee. This committee functions to identify needs, plans for improvement to services and plans co-occurring activities for individuals diagnosed with co-occurring disorders. The DMH Bureau of Alcohol and Drug Abuse and the Bureau of Community Services participate in joint education and training initiatives and conduct monitoring of programs.

The DMH received funding from the Center for Mental Health Services for the Transformation Transfer Initiative (TTI), one component of which was designed to support continued training of mental health providers in assessment and treatment of co-occurring disorders. Coaching and technical assistance are also being offered to all 15 regional community mental health centers and to four state hospitals following the training. Also, the Bureau of Alcohol and Drug Abuse will continue to allocate funding to the 15 regional community mental health centers earmarked for the provision of mental illness and substance abuse treatment.

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To promote the concepts of recovery and person-centeredness into services for individuals with co-occurring disorders

Strategy: DMH will provide state-wide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values.
Performance Indicator: Improved outcomes of individuals receiving services will be reported; increased access to community based supports will be reported; increased knowledge of staff will be reported; and increased number of positive responses to the Council on Quality and Leadership’s (CQL) 21 Personal Outcome Measures (POM)© (Combined-SMHA/SSA).

Description of Collecting and Measuring Changes in Performance Indicator:
POM interviews

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

Goal: To expand and improve integrated treatment service options for individuals with co-occurring disorders

Strategy: DMH will review alternative funding to provide additional training on COD; DMH will coordinate and partner with other agencies and organizations to provide and attend COD training; and DMH will continue to monitor and review services provided by the 15 mental health regions and Mississippi State Hospital.

Performance Indicator: Number of COD trainings provided and attended and number of COD programs reviewed

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

Priority Area #3: Provision of Services for Individuals with Co-Occurring Mental and Substance Use Disorders (Combined-SMHA/SSA)

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

Strategy: Both Bureaus will collaborate in a state-wide conference planned for FY 2012 (MS School for Addiction Professionals), and both Bureaus will continue to monitor and provide technical assistance to co-occurring programs upon request.
Performance Indicator: Number of technical assistance and certification visits by DMH staff to programs implementing and/or planning programs to serve individuals with co-occurring disorders will be tracked; conference planning minutes and conference agenda; and Division of Children and Youth Monthly Reporting Form to track technical assistance provided

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

SUBSTANCE ABUSE SERVICES
GOALS/STRATEGIES
FY 2012-2013

Substance Abuse Prevention Services

The Bureau of Alcohol and Drug Abuse will spend at least 20 percent of the Substance Abuse Prevention and Treatment Block Grant to educate and counsel individuals on substance abuse, provide prevention public awareness activities to reduce the risk of such abuse by the individuals and give priority to programs for populations that are at risk of developing a pattern of such abuse.

Goal: To implement a new State Strategic Prevention Framework Plan for providing prevention services to include objectives for workforce development, implementation of evidence-based prevention and evaluation.

Strategy: The Bureau of Alcohol and Drug Abuse staff implemented a new Strategic Prevention Framework Plan which was developed with input from DMH Prevention Services staff; alcohol, tobacco and drug (ATOD) abuse Prevention Coordinators, the Executive Prevention Council (MEPC) and technical assistance and feedback provided by the Center for Substance Abuse Prevention (CSAP). This plan became effective October 1, 2006.

Indicator: Bureau staff will continue to make revisions when necessary.

Description of Collecting and Measuring Changes in Indicator: A record of all revisions will be kept by the MEPC and noted in meeting minutes.

Goal: To increase communication and collaboration between the bureau and prevention professionals from programs funded and/or certified by DMH.

Strategy: The bureau will host and facilitate biannual meetings to address the latest
technology and national and state initiatives in the field of prevention.

Indicator: Program personnel will be given the opportunity to showcase activities or programs to their colleagues.

Description of Collecting and Measuring Changes in Indicator: Showcase, sign-in sheets and agendas.

Goal: To increase the knowledge and awareness of workforce professionals and other social service personnel on current issues in substance abuse prevention.

Strategy: Prevention personnel will conduct trainings on current topics related to substance abuse prevention at statewide or regional conferences such as the Annual summer School offered through Jackson State University, Mental Health/Intellectual and Developmental Disabilities Conference, and the Annual Juvenile Justice Conference. Prevention personnel will also host the Mississippi School for Addiction Professionals. Programs funded or certified by DMH will be encouraged to attend and/or present at conferences. A current listserv will be maintained by BADA to communicate technology from prevention professionals from around the country to our community-based providers in Mississippi.

Indicator: Summary of training provided by prevention personnel quarterly.

Measuring Changes in Indicator: Evaluations from trainings and conferences

Goal: To maintain the current network of substance abuse prevention service providers across the state.

Strategy: DMH Bureau of Alcohol/Drug Abuse will continue to fund prevention activities, statewide. These activities will continue to be provided through the 15 community mental health/mental retardation centers and 14 free-standing programs. Prevention programs will continue to utilize at least three of the six prevention strategies established by Center for Substance Abuse (CSAP), the DMH’s federal funding source. These strategies include:

1. Information Dissemination
2. Education
3. Alternatives
4. Problem Identification and Referral
5. Community-Based Process
6. Environmental

All prevention programs will submit contracts with the Bureau of Alcohol and Drug Abuse. The information received through the database includes specific activities, responsible staff,
location, type of activity (approved, promising, model), strategy utilized, number of participants and participant demographic information.

Indicator: Quarterly progress reports will be submitted to the Prevention Services Director by the DataGadget Coordinator describing the programs' activities, strategies, progress and accomplishments.

Measuring Changes in Indicator: Documentation will be kept on programs which have implemented these activities, based on monitoring conducted during regularly scheduled biannual onsite visits.

Goal: The State will work with selected community subrecipients to implement evidence-based prevention programs.

Strategy: Prevention programs which submitted a Request for Proposal (RFP) and were funded were required to implement at least one effective evidence-based curriculum spending at least 20% of direct service hours dedicated to the implementation of an evidence-based curriculum. The type of program (effective or model) is determined by the list developed by the National Registry of effective Programs (NREP). Information collected with the SureTool includes process data such as intervention, dosage and the number and demographic characteristics of persons served. Bureau of Alcohol and Drug Abuse staff will conduct site reviews annually which will ensure compliance with the Operational Standards for Community Mental Health/Intellectual and Developmental Disabilities Services and programmatic visits to monitor program implementation. Programs will submit quarterly reports describing progress made toward achieving outcomes and objectives and documenting activities of evidence-based programs including any fidelity or adaptation issues encountered during implementation.

Indicator: Quarterly progress reports will be submitted to Prevention Services Division by the DataGadget Coordinator indicating the number of programs utilizing evidence-based curricula and the number of persons who complete an evidence-based curriculum.

Measuring Changes in Indicator: Documented increase in number of evidence-based curricula implemented.
Goal: To insure that each community mental health center employs a full-time prevention staff member.

Strategy: The bureau will maintain current funding for the 15 community mental health centers.

Indicator: The number of community mental health centers which employ a full-time prevention staff member.

Measuring Changes in Indicator: Documentation for SAPT Block Grant on fulltime staff members.

Goal: To increase the number of certified prevention professionals employed at programs funded or certified by DMH.

Strategy: Through contract, the bureau will offer courses required by the certifying body at no charge to participating personnel from programs funded or certified by DMH. The courses will be offered twice on different dates and the bureau tracked the number of personnel trained.

Indicator: Summary of the number of personnel from DMH certified and/or funded programs trained and certified as prevention professionals

Measuring Changes in Indicator: Number of certified prevention personnel will be kept on file at DMH

Goal: To provide 40 hours of prevention training based on a curriculum from the Western Center for the Applied Prevention Technology (CAPT).

Strategy: The prevention coordinators from each of the 15 regional community mental health centers and at least one staff member from the free-standing prevention programs will be required to complete this training. Two 40-hour training sessions will be available in separate geographical areas of the state allowing easier access for all programs. The bureau will provide financial support to assist in allowing as many staff to attend as possible.

Indicator: Documentation that staff attended these trainings will be collected through a written record of attendance at the trainings.

Measuring Changes in Indicator: All attendance records will be sent to DMH yearly
Goal: To provide opportunities for continuing education to prevention personnel who have completed the 40 hour CAPT training to maintain an effective and trained prevention workforce, statewide.

Strategy: BADA will provide opportunities for training at no cost to attendees from programs funded or certified by the Bureau. Prevention Coordinators who have completed the 40 hour CAPT training will be required to complete 15 hours of continuing education.

Indicator: Documentation that staff attended these training sessions will be collected through a written record of attendance at the training.

Measuring Changes in Indicator: All attendance records will be sent to DMH yearly

Goal: Prevention program personnel from all programs within each of the 15 mental health regions will participate in required quarterly meetings to facilitate communication, coordination, and collaboration among the providers in an effort to improve the efficiency and quality of all programs.

Strategy: The community mental health center prevention coordinator in each mental health region will coordinate these meetings on a rotating basis.

Indicator: Agendas, attendance sheets and other required information will be submitted to the Bureau of Alcohol and Drug Abuse along with annual progress reports.

Measuring Changes in Indicator: Quarterly meeting agenda’s and sign-in sheets.

Tobacco Use Prevention


Strategy: The DMH, Bureau of Alcohol and Drug Abuse Request for Proposal (RFP) continues to require that all programs conduct 25 merchant education trainings in their region. Regions that contain more than one funded program should divide the 25 programs to eliminate the possibility of duplication. Training on how to conduct merchant education will be provided by a DMH contractor.

Indicator: Documentation in quarterly report by the DataGadget Coordinator of the number of CMHCs meeting the above training requirements.
Goal: To prevent the initiation of tobacco use by the implementation of policies, practices and programs targeting tobacco use by youth.

Strategy: The DMH staff will serve on the Mississippi’s Comprehensive Tobacco Control and Treatment Strategic Planning Committee. This committee consists of best practices, guidelines and recommendations in having a comprehensive tobacco control program. Objectives and goals in the five-year plan surround the Center for Disease Control’s four goal areas: eliminating exposure to environmental tobacco smoke, preventing the initiation of tobacco by youth, access to cessation resources for adults and youth and the development of an infrastructure for tobacco, prevention.

Indicator: Development of a final plan (MS Comprehensive Tobacco Control and Treatment Strategic Plan). Participation by prevention services staff at all committee meetings and in the development and implementation of the plan.

Measuring Changes in Indicator: Meeting minutes and agenda will be kept on file.

Goal: To reduce /prevent/delay marijuana use by youth through implementation of a targeted marijuana initiative.

Strategy: The Department of Mental Health, Bureau of Alcohol and Drug Abuse required in FY 2007 Request for Proposal (RFP) that each subrecipient initiate a program targeting marijuana use by youth. The DMH researched and identified the best evidence-based marijuana use by youth program. This information was made available to subgrantees and DMH prevention services staff assisted them in selecting the most appropriate model for their community based on their community needs and resources.

Indicator: Quarterly reports submitted to Prevention Services Division by DataGadget Coordinator.

Measuring Changes in Indicator: Documentation will be kept that programs have implemented these activities, based on monitoring conducted during regularly scheduled biannual on-site visits.

Goal: To reduce/prevent/delay alcohol use by youth through implementation of a targeted Underage Drinking Initiative.
Strategy: The BADA Prevention Services will develop and implement an underage drinking campaign for statewide implementation. The RFP required all subrecipients to implement an underage drinking campaign within their community. DMH Prevention staff researched and identified best evidence-based underage drinking campaigns. This information was made available to the subrecipients and prevention staff assisted them in selecting the most appropriate model for their community based on their community needs and resources. This strategy was aimed at changing attitudes as well as changing community ordinances, regulations, legislation and public policy to prevent the sale of alcohol beverages. Implementation began April 1, 2007 and is ongoing. Staff will continue to participate on the Mississippians Advocating Against Underage Drinking (MAAUD). BADA will maintain funding for 21 community-based agencies targeting underage drinking. Also, continue providing funding for a state level Underage Drinking Coordinator.

Indicator: Development of the RFP to include requirements and the implementation of campaigns within communities and be reported in annual progress reports.

Measuring Changes in Indicator: Documentation will be kept that programs have implemented these activities, based on monitoring conducted during regularly scheduled biannual on-site visits.

Goal: To reduce/prevent/delay methamphetamine use through implementation of a Prescription Drug Use Initiative.

Strategy: The RFP required all subrecipients to implement an initiative on prescription drug use/abuse level. The goal is to decrease the prevalence of this problem by increasing community and state awareness of prescription drug abuse. Implementation began on April 1, 2009.

Indicator: Development of the RFP to include requirements and the implementation of the initiative within communities and be reported in annual progress reports.

Measuring Changes in Indicator: Documentation will be kept that programs have implemented these activities, based on monitoring conducted during regularly scheduled biannual on-site visits.
Goal: Create a Culturally Competent service delivery system.

Strategy: All funded agencies are required to incorporate cultural competence within their Memorandum of Understanding. BADA will continue to encourage all funded agencies to utilize the Cultural Competence self-test.

Indicator: Submission RFP requirements include addressing cultural competence in annual RFP application.

Measuring Changes in Indicator: Documentation will be kept that programs have implemented these activities, based on monitoring conducted during regularly scheduled biannual on-site visits.

Substance Abuse Rehabilitation/Treatment Services

The Bureau of Alcohol and Drug Abuse will continue to provide a statewide continuum of comprehensive, accessible and affordable community-based substance abuse treatment services identified by the state that meet the person-centered needs of the individual.

Community-Based Primary Residential Services

Goal: To maintain primary residential treatment services for adult males.

Strategy: Services will be provided through community mental health centers and free-standing programs. The DMH’s Bureau of Alcohol and Drug Abuse will continue to certify and provide funding to support community-based primary residential treatment programs for adult males in the fourteen (14) CMHCs. Seven (7) free-standing programs are certified by the DMH, making available twenty-one (21) primary residential substance abuse treatment programs located throughout the 15 community mental health regions.

Indicator: The number of primary residential treatment programs for adult males certified and/or funded by the DMH, Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Goal: To maintain current programs and expand primary residential treatment services or adult females, giving first priority to pregnant women.
Strategy: Services will be provided through community mental health centers and free-standing programs. The DMH’s Bureau of Alcohol and Drug Abuse will continue to certify and provide funding to support fourteen (14) community-based primary residential treatment programs for adult females. Two of the fourteen (14) programs serve pregnant and parenting women. Six (6) free-standing programs are certified by the DMH, making available twenty (20) primary residential substance abuse treatment programs located throughout the 15 community mental health regions. Service contracts made with DMH funded substance abuse treatment programs include an assurance that states pregnant women will be given first priority for substance abuse treatment services and must be signed by the service provider. Also, DMH funded substance abuse treatment programs will submit a written report to the BADA on a monthly basis indicating the number of pregnant women served by the program.

Indicator: The number of primary residential treatment programs for adult females certified and/or funded by the DMH’s Bureau of Alcohol and Drug Abuse.

Measuring changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Goal: To maintain specialized primary residential services designed specifically for pregnant women and women with dependent children.

Strategy: Services will be provided through community mental health centers and free-standing programs. The DMH, Bureau of Alcohol and Drug Abuse will continue to certify and provide funding to support two existing primary residential treatment programs specifically designed for pregnant women and women with dependent children. In addition to substance abuse treatment, these specialized primary residential programs will provide the following services: 1) primary medical care; prenatal care and child care; 2) primary pediatric care for their children including immunizations; 3) gender specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, parenting, and child care, while the women are receiving these services; 4) therapeutic interventions for children in custody of women in treatment which may among other things address their developmental needs and their issues of sexual and physical abuse and neglect; 5) sufficient case management and transportation services to ensure that women and their children have access to the services provided by (1) through (4).

Indicator: The number of primary residential treatment programs specifically designed for pregnant women and women with dependent children certified and funded by the Bureau of Alcohol and Drug Abuse.
Measuring Changes in Indicator:  MS Substance Abuse Management Information System (MSAMIS)

Goal: To maintain specialized primary residential treatment services for adolescents.

Strategy: Community-based primary residential treatment programs for adolescents with substance abuse problems will be provided through regional community mental health centers and free-standing programs. Adolescents who have co-occurring disorders (substance abuse/mental illness) will also be accepted in these programs. Two community-based residential treatment programs for adolescents, one for male adolescents and one for female and male adolescents with substance abuse problems and mental illness will continue to be certified and funded by the Bureau of Alcohol and Drug Abuse. Another program of this type, female and male is certified and funded by the Division of Children and Youth in the Department of Mental Health.

Indicator: The number of primary residential treatment programs for adolescents certified and/or funded by the Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Goal: To continue providing treatment for substance abuse to inmates at the MS Department of Corrections in Parchman.

Strategy: As part of the admission process, each new inmate is screened for alcohol and/or drugs. If initial screening results indicate abuse with alcohol and/or drugs, inmates will be referred to the penitentiary's alcohol/drug abuse treatment program. The state penitentiary will report the number of individuals admitted to their treatment program through this screening process to the DMH.

Indicator: The number of inmates who are screened and admitted to the penitentiary's substance abuse treatment program as reported to the DMH’s Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Community- Based Transitional Residential Services

Goal: To maintain current programs and expand transitional residential treatment services for adult males.
Strategy: Services will be provided through community mental health centers and free-standing programs. DMH Bureau of Alcohol/Drug Abuse will continue to certify and provide funding to support eleven (11) community-based transitional treatment programs for adult males in the CMHCs. The DMH also certifies nine (9) free-standing transitional residential programs. There is a total of 20 transitional residential programs offered to adult males.

Indicator: The number of transitional residential treatment programs for adult males certified and/or funded by the DMH’s Bureau of Alcohol and Drug Abuse, and efforts to expand these services to other areas of the state.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Goal: To maintain specialized transitional residential substance abuse treatment services for adult males with co-occurring disorders (mental illness and substance abuse).

Strategy: The DMH has awarded funding to a community-based transitional residential treatment facility for adult males diagnosed with a co-occurring disorder. These individuals, primarily drawn from the Mississippi State Hospital population, are ready to leave the hospital but still require a supported living environment.

Indicator: Continued funding from the DMH’s Bureau of Alcohol and Drug Abuse to maintain one transitional residential treatment program for co-occurring adult males.

Measuring Changes in Indicator: Funding

Goal: To maintain current programs and expand transitional residential treatment services for adult females, giving first priority to pregnant women.

Strategy: The DMH Bureau of Alcohol and Drug Abuse has set funding of this objective as a priority. Services will be provided through regional community mental health centers and free-standing programs. The DMH’s Bureau of Alcohol and Drug Abuse will continue to certify and provide funding to support eleven (11) community-based transitional residential treatment programs for adult females. The DMH also certifies six (6) free-standing programs. There are 17 programs offered for adult females. Service contracts made with DMH funded substance abuse treatment programs include an assurance that the state’s pregnant women population will be given first priority for substance abuse treatment services. Also, DMH funded substance abuse treatment programs will submit a written report to the BADA on a monthly basis indicating the number of pregnant women served by the program.
Indicator: The number of transitional residential treatment programs for adult females certified and/or funded by the DMH Bureau of Alcohol and Drug Abuse, and efforts to expand these services to other areas of the state.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Goal: To continue providing transitional residential substance abuse treatment services for women recently released from correctional facilities. (Included in original count of transitional residential programs for women in previous objective)

Strategy: Services will be provided through a free-standing nonprofit organization. The DMH Bureau of Alcohol and Drug Abuse will continue to certify and make available funding to support a specialized transitional substance abuse treatment program for women transitioning from correctional facilities. This program also serves women and pregnant women as well from the community who are not incarcerated at a correctional facility.

Indicator: Continued funding from the DMH’s Bureau of Alcohol and Drug Abuse for transitional residential services for women transitioning from correctional facilities.

Measuring Changes in Indicator: Funding

Goal: To maintain and expand specialized transitional residential services designed specifically for pregnant women and women with dependent children.

Strategy: Services will be provided through community mental health centers and/or free-standing programs. The DMH, Bureau of Alcohol and Drug Abuse will continue to certify and provide funding to support two existing transitional residential treatment programs specifically designed for pregnant women and women with dependent children. Additionally, the BADA will add beds, specifically for pregnant women, to an existing transitional program. There will be a special emphasis placed on teaching parenting skills in this program. In addition to substance abuse treatment, these specialized transitional residential programs will provide the following services: 1) primary medical care; prenatal care and child care; 2) primary pediatric care for their children including immunizations; 3) gender specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships sexual and physical abuse and parenting, and child care while the women are receiving these services; 4) therapeutic interventions for children in custody of women in treatment which may among other things address their developmental needs and their issues of sexual and physical abuse and neglect; 5)
sufficient case management and transportation services to ensure that women and their children have access to the services provided by (1) through (4).

Indicator: The number of specialized transitional residential programs for pregnant women certified and funded by the DMH’s Bureau of Alcohol and Drug Abuse, and efforts to expand and improve these services.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

Community-Based Outpatient Services

Goal: To maintain general outpatient services (individual, group and family) in all 15 community mental health center regions.

Strategy: Outpatient substance abuse treatment services will be provided by community mental health centers and free-standing programs. DMH Bureau of Alcohol and Drug Abuse will continue to certify and fund general outpatient substance abuse treatment services in all fifteen (15) community mental health centers and certify twelve (12) free-standing programs.

Indicator: The number of programs that receive funding and/or certification from the DMH Bureau of Alcohol and Substance Abuse to provide outpatient substance abuse services.

Measuring Changes in Indicator: Funding

Goal: To maintain the provision of intensive outpatient services (IOP) for adults.

Strategy: Intensive outpatient treatment programs will be provided by community mental health centers and free-standing programs. The DMH Bureau of Alcohol and Drug Abuse will continue to certify and provide funding for 11 IOPs in the 15 community mental health centers and certify twelve (12) adult free-standing IOPs.

Indicator: The number of Intensive Outpatient Programs certified and/or funded by the DMH Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)
Goal: To maintain specialized intensive outpatient services for adolescents.

Strategy: Intensive outpatient (IOP) treatment programs for adolescents will be provided by one (1) certified/funded free-standing program and one (1) certified free-standing program. Two 10-15 week IOP treatment programs for adolescents will be maintained.

Indicator: Continued funding by the DMH Bureau of Alcohol and Drug Abuse for specialized intensive outpatient services for adolescents.

Measuring Changes in Indicator: Funding

Goal: To maintain specialized day treatment services for female inmates at the Rankin County Correctional Facility.

Strategy: Services will continue to be provided through a free-standing substance abuse service provider. Four-hour group therapy sessions will be provided for women on site, four days per week.

Indicator: Continued funding by the DMH Bureau of Alcohol and Drug Abuse for a specialized day treatment program for female inmates.

Measuring Changes in Indicator: Funding

Hospital-Based Inpatient Chemical Dependency Services

Goal: To maintain inpatient chemical dependency units at two state psychiatric hospitals.

Strategy: The Bureau of Alcohol and Drug Abuse will continue to provide funds to the adult male and female chemical dependency units at Mississippi State Hospital. The Bureau will continue to provide funding for the Residential Detoxification Program at East Mississippi State Hospital as well as certify a non-funded twenty-five (25) bed unit for adult males and 10 beds for adolescents (which also serves those with co-occurring disorders) located at the Bradley A. Sanders Adolescent Complex.

Indicator: The number of hospital-based chemical dependency programs funded.

Measuring Changes in Indicator: Funding
Substance Abuse Therapeutic Support Services

To provide a comprehensive, easily accessible network of support services that contribute to the quality of substance abuse treatment programs, provide services for specific populations, and aid individuals in maintaining sobriety after they are no longer receiving formal substance abuse treatment.

Community-Based Outreach/Aftercare Services

Goal: To maintain statewide alcohol and drug abuse outreach/aftercare services.

Strategy: Services will be provided through fourteen (14) community mental health centers and eight (8) free-standing programs and one (1) adolescent program.

Indicator: Evidence, based on monitoring activities of the Bureau of Alcohol and Drug Abuse, that aftercare/outreach services are provided in the 15 CMHC regions.

Measuring Changes in Indicator: Monitoring Visits

Goal: To continue providing substance abuse outreach services to older adults and to those who have dementia.

Strategy: Services will be provided through the 15 Community Mental Health Centers utilizing program flexibility with various treatment options.

Indicator: Evidence, based on BADA monitoring activities that these services are provided by the 15 CMHCs.

Measuring Changes in Indicator: Monitoring Visits

Co-Occurring Services

Goal: To continue treatment services for individuals with co-occurring disorders (mental illness and substance abuse) in all 15 community mental health regions.

Strategy: The Bureau of Alcohol and Drug Abuse will continue to allocate funds to each of the 15 regional community mental health centers specifically earmarked for the provision of substance abuse treatment services for individuals with co-occurring disorders (mental illness and substance abuse) as well as staff training regarding the provision of these services.
Indicator: The number of CMHCs in which specialized services for individuals with co-occurring disorders are provided.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)
DUI Diagnostic Assessment Services

Goal: To continue making available substance abuse DUI Diagnostic Assessment services to multi-offenders.

Strategy: The DMH will continue to apply the operational standards to certify interested agencies in providing DUI Diagnostic Assessment services for individuals convicted of second and subsequent DUI offenses. The purpose of this service is to maintain compliance with Mississippi’s Implied Consent Law and to evaluate the multi-offender’s need for substance abuse treatment. After the DUI assessment process is complete, if treatment is warranted, the individual will be referred to a certified substance abuse treatment program for services. DUI Diagnostic Assessment services will continue to be available in the 15 community mental health centers and fifteen (15) free-standing programs.

Indicator: The number of CMHCs and free-standing programs that provide DUI Diagnostic Assessment services.

Measuring Changes in Indicator: MS Substance Abuse Management Information System (MSAMIS)

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Goal: To continue making available substance abuse treatment services to multi-offenders.

Strategy: Substance abuse treatment services will continue to be available through the existing system (i.e., community mental health centers and free-standing substance abuse treatment programs.) If treatment is required and successfully completed, multi-offenders will be eligible to receive a reduction in their driver's license suspension time.

Indicator: Availability of funding from the DMH Bureau of Alcohol and Drug Abuse to support community-based substance abuse services for individuals referred through the DUI diagnostic assessment network.

Measuring Changes in Indicator: Funding

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Goal: To continue evaluation of the impact of the MS Zero Tolerance Law on the need for DMH funded DUI Diagnostic Assessment and treatment services for minors.

Strategy: Bureau of Alcohol and Drug Abuse staff will review the number of second and subsequent adolescent DUI offenders whose “Certification of DUI In-Depth Diagnostic Assessment and Treatment Program Completion” forms are processed through the Bureau. This required form is used by programs that are certified by the DMH to conduct DUI assessments and provide substance abuse treatment for DUI offenders.
Documentation of an individual’s completion of this process provides the opportunity for license reinstatement through the Mississippi Department of Public Safety. The Bureau will also collect information regarding new programs which address the adolescent DUI first-offender population from the Mississippi Alcohol and Safety Education Program (MASEP), the organization responsible for the provision of statewide educational programs for court-ordered DUI first offenders. Additionally, the Bureau will obtain adolescent DUI arrest record information from the Department of Public Safety (DPS), Office of Highway Safety (OHS).

Indicator: Maintenance and review of copies of adolescent DUI offender “Certification of DUI In-Depth Diagnostic Assessment and Treatment Program Completion” forms that are processed through the Bureau and records of related information obtained from the DPS/OHS and MASEP.

Measuring Changes in Indicator: BADA documentation and monitoring visits

Goal: To ensure that DMH telephone help-line numbers (toll-free and local) are made available to convicted multi-offenders.

Strategy: Staff from the Bureau of Alcohol and Drug Abuse will continue to work with the Department of Mental Health, Office of Constituency Services and the Department of Public Safety, Office of Driver Improvement to monitor the number of DUI assessment referrals. This information will be collected and evaluated on a regular basis to determine if DUI clients are utilizing the help-line numbers.


Measuring Changes in Indicator: OCS Documentation

Goal: To continue to facilitate training in the BADA adopted uniform substance abuse diagnostic assessment instrument, a required component of the Comprehensive DUI Diagnostic Assessment process, to be utilized by DUI diagnostic assessment providers.

Strategy: The Bureau of Alcohol and Drug Abuse will continue to facilitate training to DUI Assessment providers, statewide. All new service provider personnel who conduct DUI Diagnostic Assessments must receive training and become certified in the use of this instrument.

Indicator: The number of service provider personnel who receive training on the uniform diagnostic assessment instrument.

Measuring Changes in Indicator: Documentation through monitoring visits
Goal: To improve BADA’s in-house system for tracking documentation received from DUI assessment and treatment service providers regarding completion requirements for license suspension time.

Strategy: The BADA will facilitate the development of a database program into which all information received from DUI assessment and treatment service providers will be entered. Additionally, each step of the in-house process will be entered including the date the information is received, all steps involved in the in-house processing of the information and the date forwarded to the Highway Patrol, Division of Public Safety. One staff member will be in charge of the data input; however, the remaining staff will be able to review the information on their computers to answer telephone inquiries from individuals requesting the status of their information.

Indicator: Summary by the Bureau of Alcohol and Drug Abuse on improvements made to this tracking system.

Measuring Changes in Indicator: BADA documentation

Vocational Rehabilitation Services

Goal: To continue the partnership with vocational services in integrating substance abuse services for eligible individuals.

Strategy: The DMH Bureau of Alcohol and Drug Abuse and the Department of Rehabilitation Services, Office of Vocational Rehabilitation will continue to participate in an interagency effort to integrate vocational services and substance abuse treatment for individuals with alcohol and/or drug abuse diagnoses who are also eligible for VR services. These services are provided through contracts between the Office of Vocational Rehabilitation and local providers of substance abuse services.

Indicator: At a minimum, contracts for provision of services will be in effect between the Office of Vocational Rehabilitation and each of the existing transitional residential treatment programs (for specified funding levels and services).

Measuring changes in Indicator: Funding and contracts

Tuberculosis and HIV/AIDS Assessment/Educational Services

Goal: To routinely make available tuberculosis assessment and treatment services to each individual receiving treatment for substance abuse.
Strategy: All clients receiving any type of substance abuse treatment service at programs certified by the DMH will be assessed for the risk of tuberculosis and receive testing and additional needed services, if determined to be at high-risk. If clients are housed in a residential setting, transportation is provided to location where the assessment is being conducted. Additionally, clients will continue to receive educational information and materials concerning TB either in an individual or group session during the course of treatment. Client records will continue to be monitored routinely for documentation of these activities by Bureau of Alcohol and Drug Abuse staff.

Indicator: Evidence, based on monitoring activities of the Bureau of Alcohol and Drug Abuse, that program providers are in compliance with this service requirement.

Measuring Changes in Indicator: Monitoring Visits

Goal: To provide HIV/AIDS early intervention services to individuals receiving substance abuse treatment.

Strategy: All clients receiving any type of substance abuse treatment service in programs certified by the DMH be assessed for the risk of HIV/AIDS and, provide counseling to all clients who elect to receive HIV/AIDS testing. Additionally, clients will continue to receive educational information and materials concerning HIV/AIDS either in an individual or group session during the course of treatment. Client records will continue to be monitored routinely for documentation of these activities by the Bureau of Alcohol and Drug Abuse staff.

Indicator: Evidence, based on monitoring activities of the Bureau of Alcohol and Drug Abuse, that program providers are in compliance with this requirement.

Measuring Changes in Indicator: Monitoring Visits

Referral Services

Goal: To continue to publish, update biennially and distribute at no charge, the Mississippi Substance Abuse Prevention and Treatment Resources directory.

Strategy: The DMH, BADA, will continue to distribute the 2011-2012 Substance Abuse Prevention and Treatment Resources directory which includes but is not limited to all substance abuse programs certified by the DMH. The directory is used for reference and to make referrals to prevention and treatment services across the state.

Indicator: Updating and distribution of the resource directory.

Measuring Changes in Indicator: Directory updates and number of copies distribute
Goal: To continue collaboration with the DMH, Office of Constituency Services to serve individuals seeking substance abuse treatment.

Strategy: The Bureau of Alcohol and Drug Abuse will receive quarterly reports from the Office of Constituency Services indicating the number, types, and locations of calls received via its state-wide toll-free telephone number. This information will be utilized to determine types and quantity of services needed in different areas throughout the state.

Indicator: Summary of collaborative efforts between the Office of Constituency Services and the Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: Documentation of meetings

Other Substance Abuse Prevention and Treatment Support Services

To enhance the statewide system of substance abuse services through collaboration with other agencies, facilitation of training opportunities and continuing evaluation of service needs.

Collaboration with Other Service Systems

Goal: To continue participation in interagency committees, task forces and other groups related to the planning, provision and evaluation of substance abuse services.

Strategy: Bureau of Alcohol/Drug Abuse Services staff will remain active (as requested) in relevant interagency committees, task forces and other groups through their attendance at regularly scheduled meetings and participation in related activities.

Indicator: List of interagency committees, task forces and groups in which Bureau of Alcohol and Drug Abuse staff participate.

Measuring Changes in Indicator: Agendas and number of meetings and sign-in sheets

Goal: To identify substance abuse treatment needs of women receiving public assistance through the Department of Human Service’s Temporary Assistance for Needy Families program.

Strategy: The Bureau of Alcohol and Drug Abuse and the Department of Human Services will collaborate in this effort. Data collected will identify the treatment needs of women who are receiving TANF funding.

Indicator: Summary of collaborative efforts in which Bureau of Alcohol and Drug staff participate, related to the TANF program.
Measuring Changes in Indicator: Agendas, number of meetings and sign-in sheets

Bureau of Alcohol and Drug Abuse Advisory Council

Goal: To collaborate with and facilitate communication with the Alcohol and Drug Abuse Advisory Council in developing and promoting substance abuse prevention and treatment programs.

Strategy: The Advisory Council will continue to meet with the Bureau of Alcohol and Drug Abuse staff on a quarterly basis. They will continue to serve on various committees, assist in developing the State Plan for Alcohol and Drug Abuse Services, and participate in the Peer Review process and encourage family support.

Indicator: Documentation of dates, meetings and summary of activities of the Advisory Council.

Measuring Changes in Indicator: Agendas, meetings and summary of activities

Substance Abuse Prevention and Treatment Quality Assurance Services

To maintain high quality substance abuse prevention and treatment services.

Certification and Monitoring

Goal: To implement the Department of Mental Health Operational Standards for Community Mental Health/Intellectual and Developmental Disabilities Services which pertain to substance abuse prevention and treatment services.

Strategy: The DMH will continue to monitor the quality of services provided by DMH certified programs through regular on-site visits. The visits consist of reviewing the program’s services in accordance with the requirements of the standards. If a program does not meet a particular standard, then it receives a deficiency from the DMH which is submitted in a written deficiency report. In turn, the program must submit a written plan of correction to the DMH for approval. The DMH conducts a follow-up visit to verify the program’s implementation of its plan of correction. All DMH certified programs are visited by DMH central office personnel at least twice a year.

Indicator: The number of site visits conducted by Bureau of Alcohol and Drug Abuse.

Measuring Changes in Indicator: Monitoring Visits
Goal: To ensure that no program funded through the SAPT Block Grant uses funds to provide individuals with hypodermic needles or syringes which may be used for illegal drug consumption.

Strategy: Each service provider submits a detailed budget in their annual grant application to the DMH, BADA. No grants will be awarded to a service provider that designates funds to be utilized for the purchase of hypodermic needles or syringes. Additionally, all awarded funds are distributed to service providers through a cash reimbursement process. All cash requests are screened as they are received by the DMH for budgetary compliance. No service provider will be reimbursed for reported expenditures of hypodermic needles or syringes. Finally, all programs are fiscally and programmatically monitored by the DMH at least annually to determine compliance with grant and purchase of service agreements.

Indicator: Summary of findings related to compliance with grant and purchase of services.

Measuring Changes in Indicator: DMH audit of certified programs

Goal: To ensure that the State has a system in effect to protect consumer confidentiality.

Strategy: The Operational Standards for Community Mental Health/Intellectual and Developmental Disabilities Services provide extensive guidelines and regulations governing the compilation, storage and disclosure of client records that ensure clients' rights to privacy and confidentiality. This process is reviewed for compliance during regularly scheduled on-site monitoring visits by DMH staff. All DMH-certified programs are also required to provide annual training on confidentiality of client information and records. Documentation of this training is reviewed in personnel files during site/certification visits.

Indicator: Summary of findings related to compliance with consumer Confidentiality Standards by Bureau of Alcohol and Drug Abuse staff.

Measuring Changes in Indicator: Monitoring Visits/Confidentiality Standards

Peer Review

Goal: To continue conducting peer reviews of A&D funded programs.

Strategy: The development of the peer review process is to determine if a provider is meeting the Council on Quality and Leadership’s (CQL) 21 Personal Outcome measures (POM) in the provider’s provision of targeted services. Peer reviews will take place with a provider 2-4 weeks before the DMH Certification Visit. The peer review team will conduct personal interviews with individuals who are receiving services to determine the presence
of the 21 Personal Outcome Measures in the individual’s life. Interviews are based on a standardized instrument. The peer review team leader will compile a report of findings at the end of each peer review and submit to the DMH monitoring staff and the DMH Clinical Services Liaison.

Indicator: Peer review reports will be written and submitted to the DMH monitoring staff before the certification visit and the Clinical Services Liaison.

Measuring Changes in Indicator: Peer Review Monitoring and Findings

Consumer Grievances and Complaints Services

Goal: To collaborate with the DMH Office of Constituency Services (OCS) in investigating and resolving consumer complaints and grievances which are received regarding substance abuse prevention and treatment programs.

Strategy: The DMH Office of Constituency Services will continue to receive consumer grievances and complaints via the DMH toll-free Help-line. This Office will also process and attempt to resolve complaints through formal and informal procedures. The DMH, Bureau of Alcohol and Drug Abuse will receive reports and assist in resolving problems, as needed.

Indicator: The nature/frequency of calls as tracked via computerized caller information and reporting mechanisms included in the information/referral software, and periodic reports from the OCS which summarize information regarding these calls.

Measuring Changes in Indicator: OCS documentation

Performance Outcome Measures

Goal: To comply with National Outcome Measures (NOMS) as mandated by the Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT), Bureaus of SAMHSA.

Strategy: The DMH Bureau of Alcohol and Drug Abuse has established a data infrastructure in order to both develop and report performance indicators for alcohol and drug prevention and treatment services. BADA has initiated implementation of these measures as per federal guidelines.

Indicator: Implementation and reporting to CSAP/CSAT.

Measuring Changes in Indicator: MS Substance Abuse Management Information System and SmartTrack.
Goal: To continually improve the quality of data collection from DMH-funded substance abuse treatment providers.

Strategy: DMH Bureau of Alcohol and Drug Abuse staff will continue to provide technical assistance to funded substance abuse treatment providers in order to ensure the submission of timely, accurate and current service provider data. The DMH, Bureau of Alcohol and Drug Abuse will also continue to update and utilize the Bureau’s data input system for entering Treatment Episode Data Set (TEDS) data, federally-mandated data standards.

Indicator: Summary of efforts to improve the substance abuse data collection system utilized by the DMH.

Measuring Changes in Indicator: Updated data collection system

Goal: To ensure that service providers comply with CSAT guidelines related to treatment of intravenous drug users.

Strategy: The Bureau of Alcohol and Drug Abuse will continue to monitor the following CSAT requirements: 1) that programs, upon reaching 90% capacity, notify the BADA; 2) admit the individual to a program of such treatment not later than 14 days after making the request of admission; 3) if the individual cannot be placed within 14 days, they be offered interim services no later than 48 hours after the request until placement can be arranged; 4) admit the individual into an appropriate treatment program no later than 120 days after the date of the initial request; and, 5) carry-out outreach activities to encourage individuals in need of such treatment to obtain it. The Bureau will monitor these requirements through the utilization of the Bureau of Mental Health Capacity Management and Waiting List Form. All substance abuse programs must address and submit this form to the BADA in conjunction with their monthly cash reimbursement requests. The information received will identify utilization rate as well as the need for additional revisions of substance abuse treatment service provider programming and/or funding locations. Regarding outreach activities, the treatment programs are required to conduct and keep records of all outreach activities. These records are monitored by the BADA during on site visits.

Indicator: Number of programs providing services to intravenous drug users in accordance with CSAT requirements.

Measuring Changes in Indicator: Monitoring Visits and DMH documentation

Goal: To ensure that pregnant women be given preference in admission to treatment facilities.
Strategy: If a facility is unable to admit a pregnant woman due to insufficient capacity, it will make an immediate attempt to place her in another program of the same type in another location or find alternative substance abuse treatment and prenatal care. If the program cannot accomplish this within 24 hours, it will notify the Bureau of Alcohol and Drug Abuse. The Bureau will assist in locating appropriate services. The entire process will be completed within 48 hours of a woman’s request for treatment. The Bureau of Alcohol and Drug Abuse will continue to monitor this CSAT requirement through the utilization of the Capacity Management and Waiting List Form. All substance abuse programs must address and submit this form to the BADA in conjunction with their monthly cash reimbursement requests. The information received will provide immediate information to the BADA if services are not available for a pregnant woman and ensure that she receives services in another facility or that interim services are made available for the client until proper services are available. This information will also provide the utilization rate as well as the need for additional or revisions to substance abuse treatment service provider programming and/or funding allocations.

Indicator: Summary of compliance by service providers with the above requirements.

Measuring Changes in Indicator: Monitoring Visits and DMH documentation

Employee Assistance Programs Services

To facilitate statewide development of Employee Assistance Programs (EAP)

Goal: To assist DMH employees and continue to provide technical assistance to state agencies and other organizations interested in planning and/or developing employee assistance programs.

Strategy: EAP Services contracted through The Counseling Center in Ridgeland, MS will continue to provide services to Department of Mental Health employees and their families. The EAP Coordinator will work closely with The Counseling Center in order to provide assistance where needed. The EAP Coordinator will also provide training and technical assistance to other state agencies and organizations in the planning and development of their Employee Assistance Programs.

Indicator: Documentation and summary of activities and accomplishments related to the development and improvement of employee assistance programs.

Measuring Changes in Indicator: Number of Employee Assistance Programs/Activities
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