



**Mississippi
Board of Mental Health
and
Mississippi
Department of Mental Health**

**STRATEGIC PLAN
FY 2011—2021**

**Moving forward toward a
brighter future...**

Message from the Chair

The Strategic Planning Subcommittee of the Board of Mental Health has been working over the last year to refine and focus the framework of the original plan presented in 2009. Our goal has been to identify quantifiable goals that will yield tangible and measurable results as we strive to redesign the services provided by the Department of Mental Health over the next 10 years.

Whereas the original plan was based on broad-based departmental goals, this year's revision reflects the fiscal realities of the foreseeable future and represents the dedicated work of team leaders from the Department's major service areas. While embracing this year's goal of appreciable forward movement, they have honed the original document to its present edition, a much leaner iteration that preserves the original approach:

- 1) Emphasis on community-based services;
- 2) Preservation of necessary inpatient services;
- 3) Implementation of a performance-based system for evaluating effectiveness and efficiency of services;
- 4) Focus on staff recruitment and development in order to maintain the diverse, highly qualified cohort of employees necessary to meet the vision and goals of the agency; and
- 5) Development of a department-wide data management and communication system designed to enhance accurate and timely review of service delivery and budgetary data across the entire system.

Lisa Romine has been indispensable in the development of this plan. As Chair, I want to thank her and everyone who participated by responding to the committee's surveys and inquiries. Your hard work and dedication is critical to our ongoing success in this important work.

Margaret Cassada, M.D., Chair
Strategic Planning Subcommittee

STRATEGIC PLANNING SUBCOMMITTEE

Dr. Margaret Cassada, Board of Mental Health
Mr. George Harrison, Board of Mental Health
Mr. Johnny Perkins, Board of Mental Health
Mr. J. Richard Barry, Board of Mental Health
Ms. Lisa Romine, Bureau of Interdisciplinary Programs
Dr. Lydia Weisser, Mississippi State Hospital
Ms. Lynda Stewart, Division of Children and Youth

Foreword

The Mississippi Department of Mental Health (DMH) is nearing the completion of its Strategic Plan's first year in operation. I sincerely thank all the dedicated individuals who have and continue to participate in the Plan's implementation. This includes consumers, family members, advocates, community mental health centers staff, providers, and other state agencies' staff in addition to DMH staff. Completion of Strategic Plan objectives supports the shift in DMH's priorities to community-based services.

This past year has been difficult for the citizens who receive services through the mental health system and our providers with the unprecedented cuts DMH has received. Today's economic realities are not the same as those when the initial Strategic Plan was developed. Increasing community capacity when there are no additional funds available, and at the same time, deep cuts are being made in existing funding, has been difficult. However, even in this challenging climate, DMH is resolute in managing the resources we do have to continue the transformation to a community-based, recovery and resiliency focused mental health system. It may take us longer to reach our goals, but DMH's vision of the future remains the same.

I look forward to continuing our work together in the coming years. Together, we can do more to make a difference in the lives of Mississippians with mental illness, substance abuse problems, intellectual or developmental disabilities, and Alzheimer's Disease.

Edwin C. LeGrand III
DMH Executive Director

Table of Contents

| | |
|--------------------------------|---------|
| Executive Summary | Page 1 |
| Mission, Vision, and Values | Page 5 |
| Core Competencies | Page 6 |
| Organizational Overview | Page 7 |
| Services and Supports Overview | Page 9 |
| Goals and Objectives | Page 13 |
| Future Goals | Page 36 |
| Implementation | Page 39 |
| Acknowledgements | Page 40 |
| Acronyms | Page 41 |

Executive Summary

The Board of Mental Health developed and approved its first agency-wide Strategic Plan in June 2009 with implementation beginning July 1, 2009. The purpose of the Strategic Plan is to drive the transformation of the system into one that is outcome and community-based. As part of the Plan's development, the Board established the requirement for an annual revision so that DMH can make any needed changes to continue moving towards its vision. To help with this review, the Board established the 2010 Strategic Planning Subcommittee consisting of: Board members Dr. Margaret Cassada, Mr. George Harrison, Mr. Johnny Perkins, and Mr. Rick Barry; Central Office staff liaison, Ms. Lisa Romine; Clinical Services Director, Dr. Lydia Weisser, MSH; and Central Office staff, Ms. Lynda Stewart, DMH Division of Children and Youth.

The Strategic Planning Subcommittee's charge was to review and revise as necessary the Strategic Plan, which serves as a map for guiding the evolution of the DMH service system. The Board of Mental Health intends for the Strategic Plan to be a flexible, living document that has the ability to meet the needs of the people we support and face the challenges of an ever-changing environment. After a review of feedback on last year's Strategic Plan from stakeholders and discussions on emerging issues, the Board's Strategic Planning Subcommittee proposes to move from our year one objectives, which focused largely on study, to more action oriented objectives. We all agree with the need for more community-based services, but with limited resources, we face the challenge to develop a plan that takes into account not only the realities of today's economy but the need to move forward. The DMH has never before faced such economic challenges; nevertheless, we know we can make strides forward and recognize the Strategic Plan is an essential tool for system transformation.

The first major task in revising the Plan was to determine the continued relevancy of the DMH's vision. To accomplish this, internal and external stakeholders were asked to complete a Vision Feedback Survey. The survey was emailed to persons representing the Board, DMH, Advisory Councils, Advocacy Groups, Community Mental Health Centers, USM, and other providers who participated in the development of the vision in the first Plan. The survey included the 20 common themes identified during the development of the initial Strategic Plan. These themes were used in the development of the vision and goal/objectives of the FY 2010 – 2020 Strategic Plan. Persons were asked to indicate if they thought these themes still need to be addressed in the revised Strategic Plan. Nineteen of the twenty themes received a majority of "yes" responses. Based on the percentages for each item, the themes were ranked. The rank order of the twenty themes was:

1. Emphasize a community based service system
2. Explore and capture all reimbursement options
3. Enhance and restructure crisis services
4. Promote and increase consumer and family member involvement and education activities
5. Expand the use of home and community-based waiver programs
6. Develop an outcomes-driven service system that promotes quality assurance
7. Support a recovery model of service delivery that promotes evidence-based practices
8. Foster a cohesive, seamless service delivery communication among service entities
9. Emphasize person-centered services/supports
10. Stress jail diversion efforts

11. Expand housing options
12. Research national trends and other state practices
13. Emphasize anti-stigma efforts
14. Enhance the utilization of information technology
15. Promote integration of primary and mental health care systems
16. Expand alcohol and drug abuse prevention and treatment efforts
17. Increase transportation options and explore transportation alternatives
18. Develop a single point of entry system
19. Expand manpower recruitment, retention, and development
20. Develop specialized service options

The subcommittee also conducted a review of the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis report of the agency. The survey included a summarization of the items identified in the original report. The DMH SWOT Report - October 2008, was used in the development of the vision and goals/objectives of the Strategic Plan. The survey was disseminated to the individuals who participated in the initial SWOT analysis of the agency. Participants were asked to indicate if they still see the issues identified in the first SWOT report as relevant and asked to provide any additional thoughts about DMH's strengths, weaknesses, opportunities, and threats. All Strengths, Weaknesses, Threats, and Opportunities listed received a majority of "*Still Relevant*" responses.

Below is a summary of those items that all (100%) of responders think are still relevant.

Strengths

All responders reported DMH's good reputation for quality service provision, collaboration with advocacy organizations, encouragement and empowerment of families, and dedication to providing evidence-based programs and services continue to be important attributes of the agency. Quality care and 24-hour assistance and protection of the individuals served by DMH also remain relevant.

Weaknesses

All responders reported that the inadequate utilization of data gathered by DMH continues to be a weakness. Based on the survey results, limited availability of specialized services as well as inconsistent service availability across the state are still considered weaknesses of DMH. According to the responders, needs assessments should continue to be conducted to determine service development and termination, and waiting lists for psychology and psychiatry services remain lengthy.

Opportunities

All responders reported that blending funding opportunities with other agencies and building stronger relationships with regional agencies, CMHCs, and private agencies continue to be opportunities for DMH. All responders agreed that networking with public and private mental health service providers to provide training opportunities in a cost-effective manner is still significant. Incorporating mental health issues into regular educational curriculums should be pursued by DMH.

Threats

All responders reported that rising costs, funding deficits, revenue cuts, and a political environment that does not value human services continue to be relevant threats to the Department of Mental Health. Decreasing availability of workforce is also seen as a relevant threat by the responders. Access to mental health treatment continues to be reported as a significant threat.

Based on the responses to the two surveys, it was determined that the Vision and SWOT Report could be used when revising the Strategic Plan. Furthermore, the information gathered from the two surveys confirmed that the initial nine key themes which emerged were still applicable:

Accountability
Person-centeredness
Access

Community
Outcomes
Prevention

Partnerships
Workforce
Information Management

Thus, these themes were again the basis for the Plan's revised goals and objectives. The nine Goal Leaders were asked to review their goal with their team members to ensure that they not only continue to address the key themes but include more observable and measurable actions showing movement toward the vision. The Goal Leaders were: Kelly Breland and Dr. Suzanne Jourdan, Goal 1; Aurora Baugh, Goal 2; Thaddeus Williams, Goal 3; Debbie Ferguson, Goal 4; Dr. Mardi Allen, Goal 5; Wendy Bailey, Goal 6; Kris Jones, Goal 7; Michael Jordan, Goal 8; and Sabrina Young, Goal 9. The Goal Leaders met with the Subcommittee to discuss their specific goals. A summary of the finalized goals follows.

Goal 1 calls for DMH to continue to execute cost saving measures and enhance its accountability and management practices to ensure the most efficient use of its resources. Transforming to a community-based system will necessitate an increase in community capacity and require funding – both new funds and the reallocation of existing funds.

Goal 2 sets forth DMH's commitment to consumers' right to participate and have a direct and active role in all processes affecting their lives. DMH believes individuals and their families must be provided opportunities for meaningful participation in their individual treatment, and in the planning, implementation, and evaluation of mental health services on the local, state, and federal level. The Division of Consumer and Family Affairs, which is staffed largely by people who have utilized mental health services, will spearhead this effort. The Division will provide training to both service providers and individuals receiving services and review, evaluate, and enhance opportunities for consumers and family members to participate fully in all aspects of mental health services.

Goal 3 addresses the methods by which DMH intends to increase individuals' access to care and services statewide. A major vehicle for improving access to care is the design and implementation of comprehensive crisis systems for all populations served by DMH. DMH will also be expanding the use of nontraditional service delivery options. In order to move forward with DMH's transformation to a community-based service delivery system, individuals and their families must be able to access needed care and services in a timely manner.

Goal 4 highlights the transformation of a service system that is institutional-based to one that is community-based. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the redefinition of the role of institutions, collaboration with stakeholders, prioritizing and re-directing existing funding, and the development of new and innovative services as well as barriers. Goal 4 provides a foundation on which DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

Goal 5 establishes the use of evidence-based or best practice models and service outcomes. Since 2004, there has been a national emphasis on implementing evidence-based practices (EBP). DMH recognizes the gap that exists between what we know about effective treatments and the services currently offered. DMH embraces the importance of identifying and implementing EBPs within the system of care. By incorporating state-of-the-art research, clinical and administrative practices will consistently produce specific, intended results and meet scientific and stakeholder criteria for effectiveness.

Goal 6 emphasizes awareness, prevention, and early intervention in order to improve the public's understanding of mental health and how to access care. The goal centers on increasing community awareness about mental illness, intellectual and developmental disabilities, substance abuse problems and Alzheimer's and other dementia. The goal also focuses on dispelling the stigma associated with mental illness and intellectual and developmental disabilities in order to promote community integration and acceptance. Strategies for promoting early intervention, substance abuse prevention and suicide prevention are also included.

Goal 7 seeks to promote shared responsibility among communities, state and local governments, and service providers to build and strengthen the community-based system of care for individuals served by DMH. DMH recognizes that formal partnerships with traditional and nontraditional partners are critical to the overall success of the system of care.

Goal 8 addresses clear objectives for investing in employee development today and in the future to ensure DMH is well prepared to succeed in an ever-changing environment. Encouraging and supporting an expectation and appreciation for "out-of-the-box" thinking and reinforcing innovation and creativity are vital. DMH must present the Strategic Plan to staff in ways that enable all employees to understand, embrace and contribute to its achievement. "Change agents" are needed throughout the agency to continually challenge the status quo, stimulate organizational thinking and build an agency-wide understanding of evidence-based and best practices, while meeting individual and community expectations.

Goal 9 focuses on using data and available technology in fiscal and programmatic decision-making. DMH will enhance its ability to communicate effectively and share data and information across the agency. DMH will standardize data currently being collected and reported and conduct additional analysis on existing data. DMH will fully implement its central data repository project and continue activities to establish an Electronic Health Record and a Health Information Exchange. With better data and analysis, decision-making will be enhanced.

These are indeed challenging times in the provision of mental health services. However, with the continuing efforts of DMH's dedicated staff and engaged stakeholders, we are confident that DMH is moving forward toward a brighter future.

Mission, Vision and Core Values

DMH Mission

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.

Vision

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.

Core Values & Guiding Principles

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 that 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, meet 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, family members, and service providers. Through open communication, we continuously build relationships and partnerships with the people and families we serve, communities, governmental/nongovernmental entities and other service providers to meet the needs of people and their families.

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

Core Competencies

The Department of Mental Health established Core Competencies to serve as indicators of success in realizing its mission and vision. The core competencies are:

Allocating resources based on established priorities and agency vision

Demonstrating a strong commitment to excellence in services/supports delivery to promote positive outcomes for people

Practicing good stewardship with all resources

Exhibiting commitment to continual evaluation and a shift in focus to a community-based service system

Involving individuals, families, and self advocates in service planning, design, and delivery

Valuing and supporting the workforce by providing opportunities for continued education, training, and advancement

Possessing the cultural competencies necessary to work effectively with diverse people, families, communities, and workforces

Embodying an organizational culture of innovation, creativity, resourcefulness, self-evaluation, and continuous quality improvement

Collecting, interpreting, and applying information from a variety of sources when making decisions, preparing budget requests, and planning for and designing mental health policies, services, and supports

Establishing partnerships with others to achieve common goals and outcomes

Communicating effectively to promote awareness and prevention as well as to dispel the stigma of mental illness, intellectual/developmental disabilities, substance abuse, and dementia

Organizational Overview

The Mississippi Department of Mental Health's organizational structure consists of three separate but interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-Operated Facilities and Community Services Programs.

Board of Mental Health

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

As specified in MISS CODE ANN Section 41-4-7 (1972), the Board of Mental Health is statutorily responsible for such primary duties as:

- Appointing an agency director,
- Establishing rules and regulations to carry out the agency's duties,
- Setting up state plans for major service areas,
- Certifying, coordinating and establishing minimum standards for programs and providers,
- Establishing minimum standards for operation of facilities,
- Assisting community programs through grants,
- Serving as the single state agency in receiving and administering funds for service, delivery, training, research and education,
- Certifying/licensing mental health professionals,
- Establishing and maintaining a toll-free grievance system,
- Establishing a peer review/quality assurance evaluation system, and other statutorily-prescribed duties.

DMH Central Office

As specified in MISS CODE ANN Section 41-4-1 (1972), the purpose of the Department of Mental Health is:

to coordinate, develop, improve, plan for, and provide all services for the mentally ill, emotionally disturbed; alcoholic; drug dependent; and mentally retarded persons of this state; to promote, safeguard and protect human dignity, social well-being and general welfare of these persons under the cohesive control of one (1) coordinating and responsible agency so that mental health and mental retardation services and facilities may be uniformly provided more efficiently and economically to any resident of the state of Mississippi; and further to seek means for the prevention of these disabilities.

Furthermore, MISS CODE ANN Section 41-4-5 (1972) provides for the establishment of divisions within the Department of Mental Health.

The overall statewide administrative functions are the responsibility of the DMH Central Office. The Central Office is headed by an Executive Director and consists of seven bureaus and the executive division:

Bureau of Administration

Bureau of Community Services

Bureau of Mental Health

Bureau of Interdisciplinary Programs

Bureau of Alcohol and Drug Abuse

Bureau of Workforce Development and Training

**Bureau of Intellectual and Developmental
Disabilities**

Executive Division

The DMH Central Office also has a Legal Division and a Clinical Services Liaison

DMH-Operated Facilities and Community Services Programs

The DMH directly operates five psychiatric facilities, five regional facilities for persons with intellectual and developmental disabilities, and two specialized treatment facilities for adolescents. The facilities serve designated counties or service areas and offer residential and/or community services for people with mental illness, substance abuse issues, intellectual and developmental disabilities, Alzheimer's disease and other dementia.

Services/Supports Overview

The Mississippi Department of Mental Health (DMH) provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance abuse problems, and Alzheimer's disease and/or other dementia. It is our goal to improve the lives of Mississippians by supporting a better tomorrow...today.

The success of the current service delivery system is due to the strong, sustained advocacy of the Governor, State Legislature, Board of Mental Health, the Department's employees, consumers and their family members, and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

Service Delivery System

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

State-operated facilities: The DMH administers and operates five state psychiatric facilities, five regional centers, and two juvenile facilities. These facilities serve specified populations in designated counties/service areas of the state.

The psychiatric hospitals provide inpatient services for people (adults and children) with SMI and substance abuse. These facilities include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Central Mississippi Residential Center. Nursing facility services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, the psychiatric hospitals also provide transitional, community-based care.

The Regional Centers provide 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 regional centers are also a primary vehicle for delivering community services throughout Mississippi.

The two juvenile facilities, Mississippi Adolescent Center and Specialized Treatment Facility, provide specialized treatment services for adolescents.

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 the DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol/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 the DMH. 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 statewide include:

Acute Psychiatric Care
Intermediate Psychiatric Care
Continued Treatment Services
Adolescent Services

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
Community Services Programs

Special Education
Recreation
Speech/Occupational/Physical Therapies
Vocational Training
Employment Services

Community Services

A variety of community services and supports is available. Services are provided to adults with mental illness, children and youth with serious emotional disturbance, children and adults with intellectual/developmental disabilities, persons with substance abuse problems, and persons with Alzheimer's disease or dementia.

Services for Adults with Mental Illness

Crisis Stabilization Programs
Psychosocial Rehabilitation
Consultation and Education Services
Emergency Services
Pre-Evaluation Screening/Civil Commitment Exams
Outpatient Therapy
Case Management Services
Halfway House Services
Group Home Services
Acute Partial Hospitalization

Elderly Psychosocial Rehabilitation
Intensive Residential Treatment
Supervised Housing
Physician/Psychiatric Services
SMI Homeless Services
Drop-In Centers
Day Support
Mental Illness Management Services
Individual and Family Education and Support

Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Home
Therapeutic Foster Care
Prevention/Early Intervention
Emergency Services
Mobile Crisis Response Services
Intensive Crisis Intervention Services
Case Management Services

Day Treatment
Outpatient Therapy
Physician/Psychiatric Services
MAP (Making A Plan) Teams
School-Based Services
Family Education and Support

Services for People with Alzheimer's Disease and Other Dementia

Adult Day Centers
Caregiver Training

Services for People with Intellectual/Developmental Disabilities

Early Intervention
Community Living Programs
Work Activity Services
Supported Employment Services
Day Support
Diagnostic and Evaluation Services
HCBS Attendant Care
HCBS Community Respite
HCBS In-home Companion Respite

HCBS Behavioral Support/Intervention
Day Treatment
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

Alcohol and Drug Abuse Services

Detoxification Services
Primary Residential Services
Transitional Residential
Outreach/Aftercare

Prevention Services
Chemical Dependency Units
Outpatient Services
DUI Diagnostic Assessment Services

Additional Information

Additional information concerning the location of the facilities, services, and supports and descriptions of the specific services can be found on the DMH website: www.dmh.ms.gov or through DMH's Toll-Free Help Line Number: 1-877-210-8513.

Goals and Objectives

Using the mission, vision, and values, the Board of Mental Health developed goals to address the transformation of the DMH service system. These goals address the key issues of accountability/efficiency, a person-centered and driven system, access, community services, outcomes, prevention, partnerships, workforce, and information management.

DMH addresses these key issues in the Strategic Plan's goals and objectives. The goals and objectives will guide the DMH's actions in moving toward a community-based system of service delivery.

The system-wide goals are as follows:

- GOAL 1** *Maximize efficient and effective use of human, fiscal, and material resources*

- GOAL 2** *Strengthen commitment to a person-driven system of care*

- GOAL 3** *Improve access to care*

- GOAL 4** *Continue transformation to a community-based service system*

- GOAL 5** *Emphasize use of evidence-based or best practice models and service outcomes*

- GOAL 6** *Emphasize awareness/prevention/early intervention*

- GOAL 7** *Share responsibility for service provision with communities, state and local governments, and service providers*

- GOAL 8** *Empower workforce to face the challenges of an evolving system of care*

- GOAL 9** *Utilize information/data management to enhance decision-making and service delivery*

The goals and objectives are presented in two sections: FY 2011- 2015 and F Y 2016 - 2021. The first section encompasses the goals and specific objectives for the next five fiscal years. Each objective includes action plans, performance measures, timelines, and responsible parties.

The second section contains broad-based objectives for FY 2016 and beyond. DMH realizes that revisions will most definitely occur over time in order to address changes in the environment, system, and new and emerging issues/trends.



Maximize efficient and effective use of human, fiscal, and material resources

Objective 1.1 Increase efficiency within DMH

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|------|------|------|------|---------------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Finalize RFP for food services project and report related expenditure reductions | Report with savings per quarter | 2011 | 2012 | 2013 | 2014 | 2015 | Admin and appointed staff |
| b) Develop and implement recommendations for two Expenditure Reduction Projects each year across DMH facilities | Projects developed and ready for implementation with projected cost savings reported | 2011 | 2012 | 2013 | 2014 | 2015 | Admin and appointed staff |

Objective 1.2 Maximize funding opportunities

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|---------------------------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Obtain at least two new grants annually | Grant applications submitted | 2011 | 2012 | 2013 | 2014 | 2015 | Staff appointed by Executive Director |
| b) Initiate at least one blended funding option | Waiver submitted | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| c) Submit at least one new community based waiver option based on priorities established by the Board of Mental Health | Blended funding option identified and initiated | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| d) Initiate at least one integrated public/private funding venture | Public/private venture identified and initiated | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |

Objective 1.3 Revise system-wide management and oversight practices to improve accountability and performance

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|--|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Perform standardized certification survey procedures for all DMH certified programs utilizing 2011 standards | Written standardized procedures and report | 2011 | 2012 | 2013 | 2014 | 2015 | Division of Accreditation and Licensure, BCS, BIDD, BADA |
| b) Make public an annual report reflecting certification survey results | Certification Survey Report publicized | 2011 | 2012 | 2013 | 2014 | 2015 | Division of Accreditation and Licensure |
| c) Conduct revised 2010 consumer satisfaction surveys for DMH certified programs | Dates surveys completed and report of results | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| d) Establish core performance indicators and data base to be used as a means of benchmarking between like programs | Core indicator data base and benchmarking completed | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| e) Make public an annual report comparing DMH certified programs and facilities according to established performance indicators | Performance Report publicized | 2011 | 2012 | 2013 | 2014 | 2015 | Division of Accreditation and Licensure |
| f) Establish Quality Forums for the sharing of successful strategies employed by high performers based on survey findings and performance indicators | Quality Forum meetings | 2011 | 2012 | 2013 | 2014 | 2015 | Division of Accreditation and Licensure, BCS, BIDD, BADA |



Strengthen commitment to a person-driven system of care

Objective 2.1 Develop and/or expand meaningful interaction of self advocates and families in designing and planning at the system level

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|------------------|------------------|------------------|------------------|------------------|------------------|
| | | 2017 | 2018 | 2019 | 2020 | 2021 | |
| a) Integrate a transformed, recovery/evidence-based, person-driven, community-based system into the philosophy of the Department of Mental Health (by virtue of the standards, policy and procedures, and education of DMH staff) | DMH Recovery philosophy statement in the standards, P&P, and DMH webpage; Recovery Training developed and provided to DMH Central Office by consumers, family members and mental health professionals and included in DMH orientation | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DCFA and all DMH |
| b) Administer Recovery Self Assessment to DMH Central Office to determine movement towards a recovery/evidence-based, person-driven, community-based system. Upon completion of the assessment, implement an independent Recovery Self Assessment conducted by DMH certification review team and the peer review team (i.e., consumers, family members, mental health professionals, and interested stakeholders) | Results and report of the Recovery Self Assessment – Providers and Peer Reviewers Development of DMH Recovery Action Guide | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DCFA |
| c) Administer the Recovery Self Assessment to DMH certified programs and an independent Recovery Self Assessment through the peer review process of programs certified by DMH | Report of DMH and Peer of Recovery Self Assessment and Action Guide | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DCFA |
| d) Develop infrastructure/formal methods to enhance communication between local advisory councils and state advisory councils | Standards and dissemination of Recovery Competency Plan by members of local advisory councils to state planning councils | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DCFA |
| e) Utilize social network as an avenue to connect consumers and family members participating in delivery, planning, and evaluating services and provide training/ education on recovery oriented system | Increase in participation of consumers and family members in trainings and workshops | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DCFA |

Objective 2.2 Develop and/or expand meaningful interaction of self advocates and families in monitoring services

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|-------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Establish policies and procedures to ensure consumer and family participation in monitoring/evaluating the mental health system through the peer review process | Increase percentage of consumers and family members involved in the evaluation of the system; Comments received through assessment will be used to modify the program as applicable | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |
| b) Implement a peer review evaluation program certified by DMH using recovery principles and the recovery self assessment that will encompass clinical staff | Peer Review Training Manual | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA , BIDD, BADA |
| c) Train peer reviewers to evaluate a recovery oriented mental health system utilizing the recovery self assessment guide | Training conducted based on recovery model and Recovery Application Guide | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |

Objective 2.3 Develop and/or expand meaningful interaction of self advocates and families in service delivery

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|----------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Collaborate with Division of Medicaid to make Peer Specialists a reimbursable Medicaid service | Peer Support approved as a Medicaid reimbursable service | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |
| b) Develop an array of peer support services necessary for a culturally competent, recovery-based mental health system | Lists of peer support services and report on research of possible funding for services | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |
| c) Develop and implement a Peer Specialist certification and testing process | Number of self advocates certified; Roles performed by certified peer specialists within DMH certified programs | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|------|------|------|------|----------------|
| d) Pilot and evaluate effectiveness of certified Peer Specialists working in DMH certified programs | Report of support services provided and Results/perceived benefits | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |
| e) Train Peer Specialists for potential employment in all CMHC regions | Employment of peer specialists; number of peer specialists trained | 2011 | 2012 | 2013 | 2014 | 2015 | DCFA |



Improve Access to Care

Objective 3.1 Establish equitable access to services statewide

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|--|
| | | 2018 | 2019 | 2020 | 2021 | 2022 | |
| a) Develop plan for future expansion of targeted services in unserved/underserved areas utilizing established priorities and trends report | Prioritized Targeted Expansion Plan based on trends report developed and submitted to Executive Director as tool to be used in making future expansion decisions | 2018 | 2019 | 2020 | 2021 | 2022 | Executive Director, BCS, BIDD, BADA, BMH, BIP, CSL |

Objective 3.2 Develop a comprehensive crisis response system

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|------|------|------|------|------------------------------|
| | | 2018 | 2019 | 2020 | 2021 | 2022 | |
| a) Redefine catchment areas for the crisis centers, Assertive Community Treatment (ACT) Teams, and psychiatric hospitals | New catchment areas delineated and approved | 2018 | 2019 | 2020 | 2021 | 2022 | Executive Director, BCS, BMH |
| b) Evaluate CMHC-operated crisis intervention Centers based on defined performance indicators | Monthly evaluation report generated to indicate rate of hospital diversion, length of stay, number of clients served through PACT teams/ mobile crisis services, etc. Annual report generated to indicate cost savings realized after 1 st year of all CICs being operated by CMHC | 2018 | 2019 | 2020 | 2021 | 2022 | BCS, BMH, Crisis Task Force |
| c) Establish services to divert individuals with SMI from entering the criminal justice system and require and support CMHCs' provision of assessment, triage, treatment and case management services to local county jails | Increase in number of individuals diverted from criminal justice system through the use of Crisis Intervention Teams; Increase number of cities participating in the Bureau of Justice's Partnership with cities to provide Behavioral Courts which promote assessment & treatment and divert individuals from spending time in jail | 2018 | 2019 | 2020 | 2021 | 2022 | BCS |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|--------------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| d) Examine feasibility of using ICF/MR group homes or cottages on the campuses of the Regional Centers to provide crisis and emergency respite services to people with intellectual/developmental disabilities | Report results of feasibility study on allocating percentage of ICF/MR group homes or cottages on Regional Center Campus beds for crisis/respice services will be submitted to executive director by Dec 31, 2012, to use as tool in deciding if the use of these targeted beds could be used as a future service option | 2011 | 2012 | 2013 | 2014 | 2015 | Executive Director, BIDD |
| e) Develop transition/step-down residential options for people leaving crisis intervention centers | At a minimum, arrangements for each crisis center catchment area; number of people in transition/step-down housing | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BMH |
| f) Partner with CICs operated by CMHCs to furnish crisis-oriented, specialized behavioral services on an as-needed basis for people with intellectual/developmental disabilities | Have all contracts with local CMHC operators of CICs signed and approved to provide these services by 7/1/2013 | 2011 | 2012 | 2013 | 2014 | 2015 | BIDD |
| g) Provide crisis detoxification services through CICs | Have at least one CIC transformed with operational structure in place to provide crisis detoxification services by 7/1/2013 | 2011 | 2012 | 2013 | 2014 | 2015 | BADA, BCS |

Objective 3.3 Incorporate cultural competencies into DMH policies, procedures, and practices

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|------|------|------|------|----------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Incorporate components of the approved cultural competency plan into DMH policies, procedures, and practices | Number of policies, procedures, and practices revised according to plan | 2011 | 2012 | 2013 | 2014 | 2015 | DMH |

Objective 3.4 Advance the use of nontraditional service delivery options

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|---------------------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Increase the use of respite services to prevent out-of-home placement for children/youth with SED and adults with SMI | Baseline report on number of children receiving home and community respite services; number of children diverted from hospitalization through use of respite services | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| b) Increase the ability of DMH programs to collaborate via telemedicine services with other providers throughout the state | Baseline report of current capacity. Number of reports submitted/obtained. Number of sites equipped with telemedicine capability | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA, DMH facilities |
| c) Increase availability of mobile services | Number of providers implementing PACT Teams. Number of regions that have organized CITs | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| d) Provide services outside traditional hours and days at CMHCs | Number of CMHCs converted over to live emergency/after hour's response services as required by 2011 revised standards | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| e) Make mental health services available in transitional therapeutic group homes and supported living programs for children/youth with SED | Number of children/youth seen and type of services provided in the community residential settings | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| f) Increase availability of in-home services | Number CMHC Regions that provide in-home services (Respite, WRAP, and Intensive Case Management) | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| g) Develop on-line support service options such as support groups | Number, type, and usage of on-line support services | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA, IS |

Objective 3.5 Address timeliness to services

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|------|------|------|------|---------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Establish length-of-wait admission goals for all DMH certified programs | Goals established and communicated to all service providers via revised DMH Standards; Baseline length-of-wait times as reported by providers according to DMH Standards | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| b) Evaluate effectiveness of length-of-wait admission goals in providing more timely services through DMH certified programs | Report on decrease from FY 2011 in average length-of-wait for admission | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD, BADA |
| c) Educate Chancery, Youth, and Family Court judges, clerks and law enforcement regarding changes to law/policies/procedures/fees | Number of revised commitment law information packets distributed to targeted entities | 2011 | 2012 | 2013 | 2014 | 2015 | Legal Division, BMH |
| d) Incorporate changes in the pre-evaluation screening training for service providers | Number of individuals in CMHCs re-trained on pre-screening changes | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BMH |
| e) Develop educational materials for families regarding the commitment process | Summary of changes information sheet developed and distributed to family members and/or clients served at all DMH funded or certified facilities during annual review/recertification of clients eligibility by July 1, 2011. Number of change sheets distributed | 2011 | 2012 | 2013 | 2014 | 2015 | BMH |



Continue transformation to a community-based service system

Objective 4.1 Increase system capacity for providing community living and community support options

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|------|------|------|------|----------------|
| a) Conduct statewide housing needs assessment and development of strategic housing plan for people in the DMH system | Report of findings and recommendations | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| b) Develop Strategic Housing Plan based on results of statewide housing needs assessment | Strategic Housing Plan submitted and approved | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| c) Based on Strategic Housing Plan, set operational goals and begin monitoring | Document outlining operational goals, performance indicators, timelines and responsible parties; Quarterly progress reports | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| d) Provide training and support for families, CMHC staff regarding how to care for someone with SMI living in the community | Increase in the number of training sessions and participants | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BMH, BIDD |

Objective 4.2 Expand interagency and multidisciplinary approaches to service delivery

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|------|------|------|------|----------------|
| a) Expand MAP teams for children and youth | Increase number of MAP Teams by a minimum of two each fiscal year | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |
| b) Expand MAP teams to include children with IDD | Pilot one MAP Team for children with IDD (Targeted county has not yet been identified) | 2011 | 2012 | 2013 | 2014 | 2015 | BCS and IDD |
| c) Expand adult MAP teams as funding is available | Increase in number of adult MAP teams | 2011 | 2012 | 2013 | 2014 | 2015 | BCS |

Objective 4.3 Develop a plan to redistribute portions of DMH's budget from institutional to community-based services

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|------------------|------------------|------------------|------------------|------------------|--|
| a) Expand Waiver Services to enable IDD individuals currently residing in DMH institutions who can and want to move to the community | Report to Executive Director of the number of waiver slots needed; individuals placed slots | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | IDD Facility Directors |
| b) Develop and implement, using evidence-based/best practice guidelines, a program that will prepare patients for transition to the community, and replicate at other facilities | Written program as well as policies. Implementation will be evaluated regarding the number of individuals monthly who graduate to program with follow-up to determine effectiveness of program in preventing readmissions | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | MH Facility Directors |
| c) Implement PACT team | Quarterly reports submitted by CMHC to Bureau of CS – report of goal is 36 admissions, and Diversion rate | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS |
| d) Establish a PACT team associated with each CIC | Availability of seven PACT teams | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS |
| e) Define future role of comprehensive facilities | Plan developed | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | Executive Director, BCS, BIDD, BADA, BMH |

Objective 4.4 Expand service options for special populations

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|------------------|------------------|------------------|------------------|------------------|----------------|
| a) Expand and improve service options for co-occurring disorders in adults with SMI, and children/youth with SED | Increase in appropriately identified individuals with co-occurring disorders and accurately reported by CMHCs | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS, BADA |
| b) Expand service options for people who have SMI and are homeless using the federal Project for assistance in Transition from Homelessness (PATH) grant | Increase in number of people receiving needed services | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|----------------|
| c) Complete a needs assessment and gap analysis of the nursing home population | Report summarizing needs | 2011 | 2012 | 2013 | 2014 | 2015 | BMH, BCS |
| d) Expand provision of elderly psychosocial programs provided by CMHC | Increase in number served in elderly psychosocial programs | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BIDD |



Emphasize use of evidence-based or best practice models and service outcomes

Objective 5.1 Address barriers to the implementation of evidence-based and best practices in Mississippi Mental Health System of Care

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|---------|---------|---------|---------|----------------------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Based on the EB/BP survey results, Subcommittees will address most frequently identified barriers to implementation and develop budget neutral strategies to address | Top 3 barriers will be addressed for MH: Adult, C&Y, IDD and A&D | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees |
| b) Develop networks and other mechanisms for sharing successes and addressing needs associated with implementation of EB/BPs in MS with a priority of cost containment in the provision of EB/BPs | Involve at least 3 outside agencies and 3 DMH operated or certified programs in networking | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees |
| c) Promote information sharing through an e-mail newsletter that highlights successes and ideas about EB/BPs implementation, innovative ideas and staff who demonstrate cost savings through using EB/BPs | Produce at least 2 newsletters each year | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees |

Objective 5.2 Develop strategies for integration of evidence-based and best practices into system of care

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|---------|---------|---------|---------|--|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Develop and distribute EB/BP compendium based on the needs identified from the MH, IDD and A&D subcommittee surveys. Compendiums will include information on national trends, research findings, available resources and impact on treatment outcomes, satisfaction and long term cost savings | Distribute to 100% of DMH operated or certified programs | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees |
| b) Provide follow-up consultation emphasizing use of free SAMSHA toolkits, local experts, and resource sharing to promote the integration of EB/BPs in all DMH operated and certified programs | Respond to 100% of the requests for consultation | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees |
| c) Emphasize knowledge transfer of nationally recognized EP/BPs and evidence informed models appropriate for Mississippi System of Care through collaboration with all DMH Bureaus and MH organizations by making EB/BPs a training priority | Co-Sponsor or facilitate at least 10 EB/BP training sessions/offerings per year | 2011: 2 | 2012: 2 | 2013: 2 | 2014: 2 | 2015: 2 | Goal 5 subcommittees, DMH operated or certified programs |

| Action Plan | Performance Indicator | Target Year | Responsibility | | | | | | | | | | |
|--|---|--|----------------|------|------|------|------|---|---|---|---|---|--|
| d) Increase implement EB/BPs in Mississippi System of Care by working with Divisions of Grant's Management and Accreditation and Certification to reward programs that implement EB/BPs and discourage programs from continuing to offer services that are not supported by recognized evidence on effectiveness | At least 2 new EB/BPs from a nationally recognized list will be implemented each year within DMH operated and certified MH (adult), MH(C&Y), A&D and IDD programs each year | <table border="1"> <tr> <td>2011</td> <td>2012</td> <td>2013</td> <td>2014</td> <td>2015</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table> | 2011 | 2012 | 2013 | 2014 | 2015 | 0 | 1 | 2 | 3 | 4 | Goal 5 subcommittees, DMH operated or certified programs |
| 2011 | 2012 | 2013 | 2014 | 2015 | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | | | | | | | | | |



Emphasize awareness/prevention/ early intervention

Objective 6.1 Increase community awareness and public education activities that focus on mental health issues , substance abuse, and DMH services

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|---|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Implement and evaluate a public awareness campaign for prevention of Fetal Alcohol Spectrum Disorders (FASD) targeting mental health professionals | Distribute materials to at least 200 mental health providers in at least 20 mental health programs or agencies; Launch Campaign at the 7 th Annual FASD Symposium | 2011 | 2012 | 2013 | 2014 | 2015 | FASD Director, DMH Public Info. Director |
| b) Develop and implement a plan to increase mental health awareness in the medical community on mental health treatment, commitment, etc. | Distribute at least 100 packets in the first year; Increased knowledge measured by survey | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BMH, DMH Public Info. Director, Facility PR Directors |
| c) Provide trainings to the substance abuse residential programs on the harmful effects of methamphetamine to include family members of those residing in treatment | Conduct 3 trainings beginning in FY12, with 1/3 of the treatment programs trained over a 6 month period until completion | 2011 | 2012 | 2013 | 2014 | 2015 | BADA |
| d) Expand current prevention efforts through partnerships to reduce underage drinking and to reduce/prevent marijuana use by youth | Decrease related accidents and fatalities; Measure changes in perceptions by survey results; Increase training by 10% in FY11 | 2011 | 2012 | 2013 | 2014 | 2015 | BADA |
| e) Develop public education program to educate service providers and public about how individuals with SMI and IDD are contributing, valued members of their communities | Number of developed materials disseminated | 2011 | 2012 | 2013 | 2014 | 2015 | BCS, BMH, and BIDD, DMH Public Info. Director, Facility PR Directors |
| f) Educate the public about the correlation of Down's Syndrome and Alzheimer's disease and dementia | Number of developed materials disseminated; Survey results; Number of trainings/presentations | 2011 | 2012 | 2013 | 2014 | 2015 | Division of Alzheimer's Disease and Other Dementia, DMH Public Info. Director |

Objective 6.2 Increase efforts to de-stigmatize mental health issues and expand suicide prevention

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|------|------|------|------|---|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Increase anti-stigma and suicide prevention presentations and collaborations with CMHCs, non-profits, schools and other groups in order to educate students and the community on mental health and suicide prevention | Increase number of presentations/ collaborations by 10% each following year; Increased knowledge measured by surveys | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Public Info. Director, Facility PR Directors, Think Again Network, Suicide Prevention Coordinator |
| b) Expand anti-stigma and suicide prevention efforts to the faith-based and business communities to increase knowledge of mental health and suicide prevention | Increased knowledge measured by surveys; Participate in at least 15 faith-based activities in FY12 and 13; Participate in at least 15 business activities in FY14 and 15 | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Public Info. Director, Facility PR Directors, Think Again Network, Suicide Prevention Coordinator |
| c) Partner with the Army and National Guard to coordinate and sponsor (with funds from MSH Friends Organization) a campaign for the military to increase their knowledge of mental health and suicide prevention | Increased knowledge measured by surveys; Training for military personnel; Educational materials developed and distribute at least 1,000 in FY11 | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Public Info. Director, MSH PR Staff, Friends of MSH, Army and National Guard Joint Behavioral Health Team |
| d) Implement and evaluate the "Possibilities through Abilities" campaign to educate Mississippi businesses about intellectual and developmental disabilities and possible employment opportunities through IDD community service programs | Reach at least 10 businesses in FY11 and increase by 10% each fiscal year; Number of new employment opportunities gained | 2011 | 2012 | 2013 | 2014 | 2015 | Abilities Awareness Council, IDD Facility PR Directors, BIDD, DMH Public Info. Director |
| e) Develop youth leadership teams to help spread the anti-stigma and suicide prevention messages to other youth in their area by utilizing the Mississippi Transitional Outreach (MS-TOP) grant | Develop at least two teams in FY11 and increase number of teams by two each year | 2011 | 2012 | 2013 | 2014 | 2015 | TOP Grant Coordinator, Think Again Network |
| f) Expand Shatter the Silence suicide prevention efforts to the elderly population and their family by using current Alzheimer's and other Dementia resources to increase knowledge of suicide in the elderly | Increased knowledge measured by surveys; Participate in at least 10 events to educate public | 2011 | 2012 | 2013 | 2014 | 2015 | Suicide Prevention Coordinator, Division of Alzheimer's and Other Dementia, DMH Public Info. Director |

Objective 6.3 Utilize technology to expand current awareness and prevention efforts

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|------------------|------------------|------------------|------------------|------------------|---|
| a) Develop two educational videos each year on mental health topics to share on YouTube as an effective and efficient way to reach new audiences | Number of hits/views on the two videos developed each year; Survey results from focus group | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | DMH Public Info. Director, Facility PR Directors, Videographer |
| b) Increase usage of DMH’s Talk About It program through promotion and evaluate the effectiveness of the program to access information and help | From FY10, increase usage of program by 10% each fiscal year; Evaluation report of response time, log-in numbers, demographic data and poll numbers | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | OCS, DMH Public Info. Director, Facility PR Directors |
| c) Develop a searchable database on DMH’s Web site for the public to locate available services in their community | Developed database; At least 100 hits in the first year | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | IS , DMH Public Info. Director, OCS |



Share responsibility for service provision with communities, state and local governments, and service providers

Objective 7.1 Increase effectiveness of collaboration among community mental health providers (inclusive of CMHCs), state agencies, governmental entities and non-governmental entities

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|------------------|------------------|------------------|------------------|------------------|--|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Develop mutual strategies to negotiate new system and service delivery arrangements | Number of mutual strategies developed (i.e. crisis center redesign, DMH standards development) | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS, BIDD, BADA, BMH |
| b) Develop stronger voice related to issues affecting the public mental health system | Number of Legislative Action Alerts, Legislative support of DMH goals – funding and votes in favor | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | Executive Director, DMH Legislative Team, BCS, BIDD, BADA |
| c) Facilitate change in policy, practice, and programs | Number of changes to policies, practices, and programs | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | Executive Director, Legislative Team, BCS, BIDD, BADA, BMH |
| d) Conduct evaluation of desired outcome of mutual strategies, changes to policy/practice/law and programs | Evaluation report based on measures related to revisions | 2 0 1 1 | 2 0 1 2 | 2 0 1 3 | 2 0 1 4 | 2 0 1 5 | BCS, BIDD, BADA, BMH |



Empower workforce to face the challenges of an evolving system of care

Objective 8.1 Increase opportunities for direct support professionals

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|--|
| a) Provide increased educational opportunities for Direct Support Professionals (DSPs) through live and web-based training programs. | Increase the number of educational opportunities currently offered to DSPs each year by at least one; Increase the number of DSPs in attendance by 10% annually | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Professional Development Director, Facility Staff Development Directors |
| b) Identify new non-monetary incentives and support options for Direct Support Professionals | Increase by one the number of non-monetary incentives currently offered to DSPs each year | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Professional Development Director, Facility Staff Development Directors, Facility Friends Organization |
| c) Create regional Direct Support Professional Conferences/Workshops for community and facility-based DSPs | Apply for Council on Developmental Disabilities Grant for monetary support; Number of DSPs trained | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Professional Development Director, Facility Staff Development Directors, Facility Friends Organization |

Objective 8.2 Develop a comprehensive Human Resources Plan

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|--|
| a) Increase employee retention rates by decreasing employee turnover | Decrease employee turnover by 2% annually | 2011 | 2012 | 2013 | 2014 | 2015 | Facility Human Resources Directors, Staff Development Directors, and DMH Professional Development Director |
| b) Develop a comprehensive plan for using technology to improve the system of training and certification for DMH employees | Increase the number of training and certification opportunities on-line by 5% annually | 2011 | 2012 | 2013 | 2014 | 2015 | BWDT and representatives from BCS, BIDD, BADA |

Objective 8.3 Increase the number of student interns, externs and residents utilized by DMH

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|---|-------------|------|------|------|------|---|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Increase internship and field placement opportunities throughout the agency | Increase field placement opportunities by 2% annually | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Public Info. Director, Facility PR Directors, Facility Human Resource Directors, Director of Professional Development |

Objective 8.4 Increase DMH educational enhancement and leadership development programs

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|-------------|------|------|------|------|---|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Increase cross-training initiatives among DMH staff to allow them to function in a community based setting | Increase cross-training initiatives by 5% annually | 2011 | 2012 | 2013 | 2014 | 2015 | DMH Professional Development Director, Facility Staff Development Directors |
| b) Provide updates to DMH staff about the Strategic Plan as changes occur. | Report documenting number of training sessions, number of staff in attendance, and evaluation of training | 2011 | 2012 | 2013 | 2014 | 2015 | BIP, DMH Public Info. Director, DMH Professional Development Director, Facility Staff Development Directors |



Utilize information/data management to enhance decision-making and service delivery

Objective 9.1 Develop a department-wide data management system

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|--|-------------|------|------|------|------|--|
| | | 2011 | 2012 | 2013 | 2014 | 2015 | |
| a) Establish Data Task Force to enhance communication and share information on IT projects, plans and future directions, hardware, software, email, etc. | Quarterly newsletter submitted via email/ internet | 2011 | 2012 | 2013 | 2014 | 2015 | IS Director, Bureau Directors |
| b) Continue to build infrastructure and refine the ability to report client level data. | 100% Compliance with submission of required data by all MH facilities and CMHCs with 5% error rate or less | 2011 | 2012 | 2013 | 2014 | 2015 | IS Director, Bureau Directors |
| c) Integrate Bureau of IDD data into CDR | Activity reports by consultants regarding progress on defined scope of work. | 2011 | 2012 | 2013 | 2014 | 2015 | IS Director, Director of BIDD |
| d) Expand reporting capabilities of the CDR by creating procedures for requesting ad hoc reports | Procedures developed and disseminated | 2011 | 2012 | 2013 | 2014 | 2015 | IS Staff |
| e) Create application for viewing and creating reports from website | Functional application | 2011 | 2012 | 2013 | 2014 | 2015 | ITS consultant, IDD staff; local providers |
| f) Develop and implement a comprehensive Electronic Provider Management System to track trends, deficiencies, serious incident reports, waivers, grievances, and complaints, and certification for all DMH-certified programs | Functional system that meets DMH requirements | 2011 | 2012 | 2013 | 2014 | 2015 | IS Staff, DMH Bureaus, DMH DUG |
| g) Develop agency intranet system | Functional DMH Intranet | 2011 | 2012 | 2013 | 2014 | 2015 | IS Staff |

Objective 9.2 Establish a road map for migration to an Electronic Health Record (E.H.R.) and/or Health Information Exchange (HIE)

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|--|--|-------------|------|------|------|------|----------------------------|
| a) Work with ITS/other consultants to implement HIE | 100% Implementation | 2011 | 2012 | 2013 | 2014 | 2015 | IS Task Force |
| b) Establish DMH-EHR task force comprised of clinical and IT staff to facilitate EHR migration | Activity reports by consultants regarding progress on defined scope of work | 2011 | 2012 | 2013 | 2014 | 2015 | IS Task Force, All Bureaus |
| c) Continue researching available funding | Summary report of possible grant funding opportunities and any subsequent applications | 2011 | 2012 | 2013 | 2014 | 2015 | IS Task Force, All Bureaus |
| d) Implement an EHR system in all DMH programs (as per impending federal mandate) | 100% Implementation | 2011 | 2012 | 2013 | 2014 | 2015 | IS Task Force, All Bureaus |

Future Goals

Fiscal Year 2016 and Beyond...

The goals and objectives for Fiscal Years 2011-2015 are the foundation of the Department of Mental Health's Strategic Plan. However, long-range planning is an essential component of any strategic plan. This section includes generalized objectives for Fiscal Year 2016 and beyond. With the successful completion of short-term objectives, it is expected that these longer-range objectives will become more specific as the time to implement them moves closer.

Goal 1 Maximize efficient and effective use of human, fiscal, and material resources

Explore the use of fiscal intermediaries as a method of allowing individuals greater control over how and where they receive services

Expand stakeholder involvement in resource planning

Increase tiered service options

Shift or obtain new funding for emerging services

Obtain all available home and community-based waivers

Increase flexibility in use of funds to support new and innovative services

Goal 2 Strengthen commitment to person-driven system of care

Include a self advocate on the Board of Mental Health

Develop certification for Transition/Community Resource Peer Specialist (Bridger)

Determine need for certification of peer specialist in other specialized areas such as Disaster Relief, Housing, Dual Diagnosis, Forensics, Crisis Intervention, Young Adult, and Family

Utilize Consumer Satisfaction Survey data as a resource in measuring a program's overall performance

Promote the inclusion of information about the importance of consumer and family involvement into curricula for areas of study such as social work, psychology, counseling, etc.

Goal 3 Improve access to care

Provide crisis services statewide for IDD and A&D

Implement a "No Wrong Door" (single point of entry) approach to accessing information and referral services

Integrate mental health care/services with primary health care

Increase access to voluntary psychiatric treatment commitment

Goal 4 Continue transformation to a community-based service system

Create seamless system of care for individuals with mental health needs

Maintain and continue growth of service capacity in the community

Assess the need for new and emerging services; respond by developing new funding mechanisms or shifting existing funding to provide services, as appropriate

Expand the growth of service capacity for existing home and community-based waivers, and expand the populations served by the waiver programs

Implement “money follows the person” approach to service delivery

Goal 5 Emphasize use of evidence-based or best practice models and service outcomes

Incorporate evidence-based or best practices in all services supported with funding from the DMH

Establish a research and development center

Goal 6 Emphasize awareness/prevention/early intervention

Conduct annual town hall meetings across the state

Implement a mental health awareness/anti-stigma campaign targeting men

Expand education initiatives with healthcare professionals

Expand suicide prevention efforts to include all ages

Explore the use of new technology and social media to further awareness/prevention/early intervention efforts

Goal 7 Share responsibility for service provision with communities, state and local governments, and service providers

Increase availability of services at partner locations

Implement a true system of care to wrap all services around individuals and their families

Establish a census management system between facilities and community service providers

Increase collaboration and funding from local governments

Established system of care is supported by service providers, state and local governments and incorporates natural support systems

Goal 8 Empower workforce to face the challenges of an evolving system of care

Provide training to workforce on evidence based and best practices

Establish cross training as standard practice

Increase utilization of data by workforce in making clinical and administrative decisions

Expand efforts to attract youth to careers in public mental health

Institute Health and Wellness programs agency wide

Goal 9 Utilize information/data management to enhance decision-making and service delivery

Increase scope of data analyses by employing a full-time Data Analyst

Utilize electronic record keeping system-wide

Develop electronic identification card system

Implementation

With the Board of Mental Health's approval of the Strategic Plan, work will begin immediately on action plans for FY 2011. As in FY 2010, implementation of the Plan will utilize a goal-based approach. Each Strategic Plan goal will have a goal leader and team members. The goal teams will be comprised of members from across the DMH, consumer/advocate groups, CMHCs, family members, advisory councils, providers, and other state agencies.

Monitoring progress toward meeting objectives will be ongoing and progress reports will be presented to the Board quarterly. Information will be presented routinely to the Board of Mental Health concerning any special activities that occur, completion of action plans, necessary changes, etc.

As stated in the first Strategic Plan, funding will always be an issue. Learning how to think creatively in shifting existing resources and maximizing the use of existing funding will be crucial. Preserving and continuing provision of mental health, intellectual/developmental disabilities, substance abuse and Alzheimer's Disease and other dementia services is paramount.

The vision of transformation to a community-based system remains. With DMH staff and external stakeholders working meaningfully and positively together, steps can be made in moving forward toward a brighter future.

Acknowledgements

The Board, Executive Director, and Strategic Planning Subcommittee sincerely thank all the individuals who provided ideas and suggestions and participated in various activities of the Plan's revision. This includes not only DMH staff, but stakeholders and others in the mental health system. We greatly appreciate everyone's efforts with this important endeavor and look forward to ongoing collaboration.

Listed below are individuals who contributed to specific sections of the revised Strategic Plan.

Vision and SWOT Surveys and Reports

Lisa Romine, BIP
Lynda Stewart, C&Y
Kris Jones, BIDD

Goals, Objectives, and Action Plans

Lisa Romine, BIP, Board Strategic Planning Subcommittee
Dr. Lydia Weisser, MSH, Board Strategic Planning Subcommittee
Kelley Breland, MSH, Goal 1 Team Co-Leader
Dr. Suzanne Jourdan, MSH, Goal 1 Team Co-Leader
Aurora Baugh, BCS, Goal 2 Team Leader
Thaddeus Williams, BCS, Goal 3 Team Leader
Debbie Ferguson, CMRC, Goal 4 Team Leader
Dr. Mardi Allen, CSL, Goal 5 Team Leader
Wendy Bailey, CO, Goal 6 Team Leader
Kris Jones, BIDD, Goal 7 Team Co-Leader
Kathy Van Cleave, Goal 7 Team Co-Leader
Michael Jordan, BWDT, Goal 8 Team Leader
Sabrina Young, SSMH, Goal 9 Team Leader

Strategic Plan Document Preparation

Lisa Romine, BIP
Lynda Stewart, C&Y
Wendy Bailey, CO

Acronyms

| | |
|-----------|---|
| ACT Teams | Assertive Community Treatment Teams |
| Admin | Bureau of Administration |
| AMAP | Adult Making-a-Plan Teams |
| A&D | Alcohol and Drug |
| BADA | Bureau of Alcohol and Drug Abuse |
| BCS | Bureau of Community Services |
| BIDD | Bureau of Intellectual and Developmental Disabilities |
| BIP | Bureau of Interdisciplinary Programs |
| BMH | Bureau of Mental Health |
| Board | Board of Mental Health |
| BP | Best Practices |
| BWDT | Bureau of Workforce Development and Training |
| CDR | Central Data Repository |
| CE | Continuing Education |
| CIC | Crisis Intervention Center |
| CIT | Crisis Intervention Training |
| CME | Continuing Medical Education |
| CMHC | Community Mental Health Centers |
| CMS | Center for Medicaid/Medicare Services |
| CO | Central Office |
| CSL | Clinical Services Liaison |
| C & Y | Children and Youth |
| DCFA | Division of Consumer and Family Affairs |
| DMH | Department of Mental Health |
| DSP | Direct Support Professional |
| DUG | Data User Group |
| EAP | Employee Assistance Program |
| EBP | Evidence-Based Practice |
| EHR | Electronic Health Records |
| FASD | Fetal Alcohol Spectrum Disorders |
| HIE | Health Information Exchange |
| ICF/MR | Intermediate Care Facilities for the Mental Retarded |
| IDD | Intellectual and Developmental Disabilities |
| IS | Information System |
| IT | Information Technology |
| ITS | Information Technology Service |
| LPC | Licensed Professional Counselor |
| MAP Teams | Making-a-Plan Teams |
| NAMI | National Alliance on Mental Illness |
| OCS | Office of Constituency Services |
| PACT | Program of Assertive Treatment |

| | |
|--------|---|
| PATH | Projects for Assistance in Transition from Homelessness |
| PLACE | Professional Licensure and Certification |
| PR | Public Relations |
| RFP | Request For Proposal |
| SAMSHA | Substance Abuse and Mental Health Services Administration |
| SED | Serious Emotional Disturbance |
| SLCR | State Level Interagency Case Review |
| SMI | Serious Mental Illness |
| SWOT | Strengths, Weaknesses, Opportunities, and Threats |
| WRAP | Wellness Recovery Action Plans |