XPand Asset-Based Implementation to Address Disparities and Disproportionalities in Human Services and Behavioral Health Care

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THE MISSISSIPPI DEPARTMENT OF MENTAL HEALTH

SUPPORTING A BETTER TOMORROW...TODAY

Executive Summary

Asset-based implementation to address disparities and disproportionalities in human services and behavioral health care for youth and families who are racial minorities, ethnic minorities, and/or lesbian, gay, bisexual, transgender (LGBT) minorities aligns with national System of Care (SOC) values and principles by advancing cultural and linguistic competence for communities in transition. The need for greater understanding of the disparities and disproportionalities that are experienced by these populations is an ongoing concern among SOC community service providers, administrators, and family members.

Substance abuse and mental health professionals in Mississippi are struggling with how to fully expand service access, availability, and utilization for youth and young adults, ages 14-21, with SED who are transitioning from child mental health services to adult mental health services and/or from an institutional setting to the community. Many racial and ethnic minority youth, for example, are within what has been described as a "school-to-prison pipeline" and experience disparities across multiple life domains. Youth who are LGBT experience frequent psychological and social challenges related to the coming out process, varying levels of acceptance and support, and the threat of social exclusion ranging from negative beliefs and attitudes to bullying, harassment, and abuse (Gamache, Lazear, Poirier, & Delaney, 2011). These overlapping challenges are best addressed with a network of support, collaborative partnerships to provide resources, and a System of Care (Boyd, 1992; Hernandez, Nesman, Mowery, & Gamache, 2008).

This document provides the following two main parts:

- ***Part I: Background*** contains statewide statistics on overall transition-age youth disparities and disproportionalities, in addition to county-level data according to race/ethnicity/LGBT where available; and

- ***Part II: Behavioral Health Disparities Impact Statement*** contains specific information regarding subpopulations in the proposed geographic service region, program activities, data collection and reporting, and plans for developing policies and procedures that will address disparities and disproportionalities.

Table of Contents

Part I: Background

Young adulthood is a critical time in human development. The transition from childhood to adult life can be very challenging. During this period, individuals transition into unfamiliar roles that must be maintained indefinitely. This transition can involve completing school, securing employment, becoming financially independent, establishing a residence, maintaining stable relationships, and becoming a parent. To accomplish these roles, young adults must develop good interpersonal skills, sound judgment, and a sense of personal responsibility and purpose (U.S. Government Accountability Office, 2008). This task is even more complex and daunting for the 34,194 youth and young adults in Mississippi with severe emotional disturbance (SED; MDMH state plan, 2015). This population has a higher dropout, arrest, and unemployment rate than their peers without SED. Young adults with SED are nearly 14 times less likely to complete high school and are 34-82% more likely to be unemployed after exiting high school than their peers without SED (Blau & Stroul, 2008).

Mississippi (2013)		
Population	**Estimate**	**Percent**
Total	2,976,872	100%
Male	1,445,356	48.60%
Female	1,531,516	51.40%
Under 5 years	205,585	6.90%
5 to 9 years	206,419	6.90%
10 to 14 years	209,849	7.00%
15 to 19 years	218,213	7.30%
20 to 24 years	218,696	7.30%
24 and under	1,058,762	35.40%
Below Poverty		
Total	684,680	23%
White	75,314	11%
African-American	273,872	40%
Asian		N/A
Other		N/A
Two or More Races		N/A
Hispanic Origin	237,583	34.70%
U.S. Census Bureau 2013 American Community Survey		

The 2014 United States Census estimates a total of 2,994,079 persons reside in the state of Mississippi, with nearly 36% representing youth under the age of 25. Transition-Aged Youth (TAY) ages 15-24 represents 15% of the population with 436,909 people.[1] Various challenges currently afflict the youth and overall community, many of which are governable by public health entities. Substandard levels of health, economic well-being, and educational attainment serve as critical indicators of the difficult circumstances plaguing the youth population.

In 2013, the American Human Development Project established a measure of the three indicators referred to as the Human Development Index, in which Mississippi ranked poorly. The state reports the lowest life expectancy (74.9), highest rate of persons over age 25 without a high school degree (19%), and among

the lowest in average income ($23,283).[2] This is highly pertinent to the devastating rate of poverty among children under 18 in Mississippi, which remains one of the worst in the nation. The American Community Survey in 2013 revealed nearly 1 in every 3 children live below the poverty line, compared to the national average of 1 in 5.[3] Youth living in poverty have a greater probability of developing cognitive and behavioral difficulties, and additionally drop out of school at an earlier age and face a larger span of unemployment.[4]

Mental and Behavioral Difficulties Among Youth

The Mississippi Department of Mental Health (2015) reported a prevalence of 40,667 - 48,061 (11-13%) children and adolescents 9-17 years old with serious emotional disturbances (SED) in the state, 25,879 - 33,273 (7-9%) of which were considered severe. For Mississippi youth ages 18-21, 12,393 (9.2%) were recorded with SED as well.[5] In 2014, 34,194 youth ages 13-20 were treated for SED through State community mental health services.

13-20 Year Olds Receiving Treatment at CMHC's (Statewide) with SMI/SED by Race and Gender		
Mississippi (2012)		
	Female	**Male**
American Indian/Alaskan Native	11	31
Asian	8	10
Black/African-American	4,307	6,635
Native Hawaiian or Pacific Islander	3	1
White/Caucasian	3,147	4,101
Hispanic or Latino	84	117
Hispanic (Origin Not Available)	44	41
More than one race	54	73
Race not available	101	117
Totals	7,759	11,126
Totals All Gender	18,885	

The Youth Risk Behavior Survey (2013) also reports approximately 25.5% of high school students in Mississippi felt sad or hopeless. In addition, 16.9% seriously considered attempting suicide, 14.3% made a suicide plan, and 10.9% attempted suicide (3.3% resulted in injury, poisoning, or overdose that had to be treated by doctor or nurse).[6] Data from the Mississippi Department of Health and Human Services indicates that 26% or 1 in 4 high school students (grades 9-12) in Mississippi exhibit depressive symptoms. Of the students surveyed, 13% indicated that they had contemplated suicide in the past year.

A recent study revealed 39% of students in middle and high schools located in limited mental health regions engaged in deliberate self-harm (DSH), and 21% have engaged in over five separate DSH incidents.[7] Results from this study

demonstrated significant data that African American males and those with low income families experienced the highest rates of DSH. Overall, youth engaging in DSH commit a range of behaviors that include self-cutting, self-burning, severe self-scratching, self-biting until breaking skin, self-banging, and self-punching. [8,9,10,11] Individuals who engage in DSH are at heightened risk for suicide, and are associated with negative intrapersonal and interpersonal experiences such as shame, social isolation, and psychological suffering and distress, making it of great public health significance. [8,12]

In congruence with the results of such studies, African Americans are statistically more at risk for negative outcomes such as lifetime cigarette use and suicidal ideation. [6] The Mississippi State Department of Health (MSDH) revealed that in 2011 African American persons of all ages were also more than twice as likely to report receiving no emotional support (15.6%) than all White people (6.7%), and youths in the 18-24 age group followed a similar trend (14.9% for African Americans vs. 7.6% for Whites); the group with the highest rates were those whose annual income was below $15,000 (21.1%).[13] Historically negative race relations (historical traumas) in the state of Mississippi represent a possible cause behind many of the prevalent emotional and behavioral issues affecting African Americans.[14]

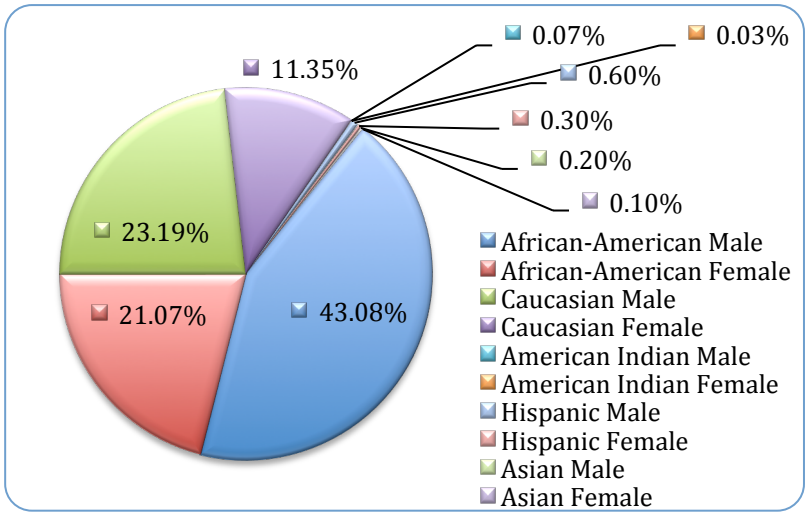
Appropriate Treatment for Youth

SED and many similar developmental disorders (DD) and mental disorders are mostly treatable/manageable. [15] However, the need for early assessment and community treatment programs is essential to aiding the thousands of children who are not treated long enough or at all. A high risk for poor health and suicidal ideation typically ensues.[5] Most mental and behavioral issues require a System of Care (SOC) that includes an individual's family and community, which is proven to produce positive outcomes and is cost effective.[15] In 2011, Mississippi failed to facilitate children with SED with the appropriate emergency transportation services, comprehensive assessments, case management, and in-home behavioral support services.[16]

Multidisciplinary Assessment and Planning (MAP) teams are responsible for coordinating and providing such necessary treatment programs and services, yet there is a need to extend this service to all communities in Mississippi. Only 1,266 children and families with SED were served by 36 MAP teams in 2008, and conservative [financial] estimates show that at least ten times that population can be appropriately served by MAP teams, though an expansion of professionals and stakeholder members would be necessary. Without suitable treatment and support, children and adolescents perform poorly in school, drop-out rates heighten, and many end up in the juvenile justice system. [15]

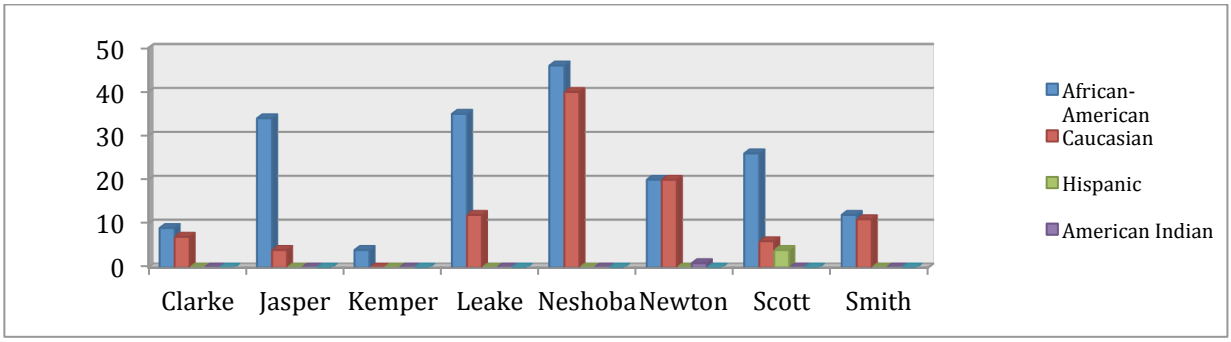
Juvenile Crime and Mental Health Concurrence

In 2012, there were approximately 14,568 arrests of youth ages 7-19 (state maximum age for a juvenile is 17; 66 exceptions applied) in Mississippi. Of that sum, 1,600 were status offenses and 12,968 were delinquent offenses.

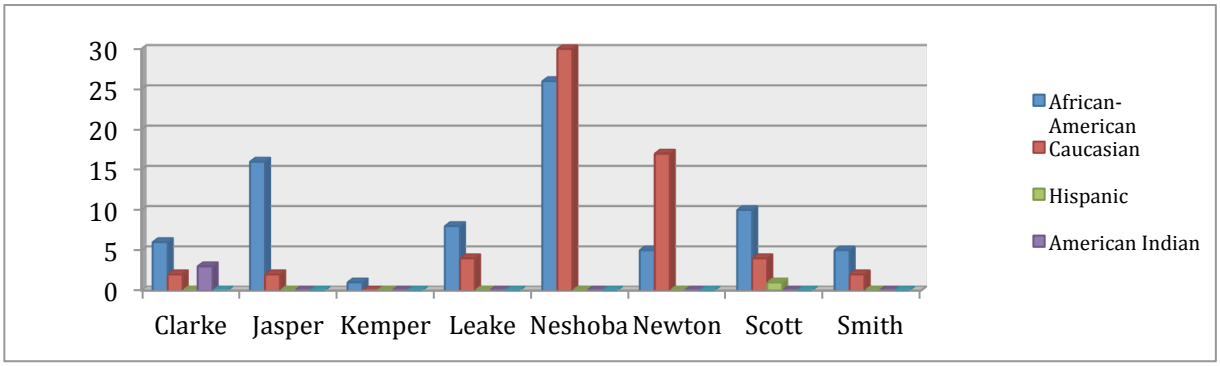


The total of those in the TAY (14-19) was 12,004, while the remaining 2,564 were children under 14 years old. African American males constituted just under half of all incarcerations. The next highest rates were for African American females and White males, which each registered 1 out of every 5 juvenile referrals. The top 5 offenses reported were: (1) disorderly conduct, (2) simple assault, (3) child in need of supervision, (4) shoplifting, and (5) malicious mischief.[17]

Juvenile Justice Dispositions by County-**Male Youth**



Juvenile Justice Dispositions by County-**Female Youth**



Training Schools vs. Community Services

A total of 234 juveniles (1.6%) were committed into training schools in 2012, compared to 14,456 placed in community-based programs. Community programs address rehabilitative needs of youth and seek to reduce recidivism.[17] Training schools are state facilities that create out of home placement and thus more isolation for offenders. Of those placed in training schools in 2011, 91% were felony offenders and 9% were misdemeanor offenders. Additionally, 84% were African American and 91% were males.[17] Youth diverted to training schools generally have longer track records in the juvenile justice system (1.9 years vs. 1.5 years) and a greater percent commit serious offenses (63% vs. 49.2%).[18]

Mental Health in the Juvenile Justice System

Approximately 1 out of every 5 incarcerated youth in the juvenile justice system of Mississippi suffer from a serious mental health disorder.[18] Among these youth, 56% have at least one other co-occurring disorder; adolescents usually have substance abuse or disruptive behavior disorders.[19,20] In addition, based on the known 11-13% prevalence of serious emotional disturbance (SED) among youth under 18, applying this ratio to the juvenile offenders provides an estimate of 1,900 youth that likely need mental health services.[18]

Juvenile Dispositions by County in 2012	
Clarke	27
Jasper	56
Kemper	0
Leake	59
Newton	63
Scott	51
Smith	30
Neshoba	142

According to a study of a Mississippi juvenile detention center and training schools in 2004, 59.2% of adolescents reported they had been to a mental health professional before, 25.8% reported a psychiatric hospitalization, 31% reported intentional self-infliction, 8.6% were suicidal, and 15% underwent substance abuse treatment. The most prevalent disorders according to the Adolescent Psychopathology Scale (APS) were conduct disorders (46.6%), adjustment disorders (38.6%), substance abuse disorders (35.9%), and one or more anxiety disorders (58.5%). Overall, youth in delinquent training schools had higher scores on all externalizing disorders (other than attention deficit disorder) than the youth in the detention center studied.[18] Higher scores indicate that youth in the training schools suffered from greater rates of mental health disorders.

Impact of Justice System on Youth. Juvenile offender studies suggest a significant correlation between delinquency with drug use, school problems, and mental health problems.[21] However, the findings also suggest that many youth are not only inclined by their mental disturbances, but their condition can be aggravated by the juvenile justice system when not placed in an environment conducive to rehabilitation. Justice programs such as the training schools have

shown the capability to serve more as a *stimulant* for youth crime as opposed to a suppressor. Most youth suffering with a mental health condition may instead be appropriately remedied in community-based programs that focus on the youth's health and family involvement.

Educational Attainment/Dropout Rates

According to the Mississippi Department of Education, the 2012-2013 graduation rate for high school students in Mississippi was 75.5%. The lowest graduation rate among all non-migrant/English speaking student groups was African American males (61.5%). The highest rated groups were White females (86.5%). The dropout rate of Mississippi was 13.9% in 2012-2013. Whites had a 9.9% dropout rate compared to a 17.4% rate for African Americans.[22]

XPand Counties Graduation/Dropout Rate Table, Mississippi Department of Education, 2012-2013		
County	Graduation Rate	Dropout Rate
Smith	78.70%	12.60%
Scott	77.90%	10.80%
Newton	81.70%	8.60%
Neshoba	85.90%	< 5%
Leake	75.60%	11.80%
Kemper	65.40%	27.40%
Jasper	78.35%	15.60%
Clarke	85.20%	< 5%

For the population 25 and older, the levels and prevalence of educational attainment are as follows [23]:

Educational Attainment (Percent of Population Age 25 and Older)		
	Mississippi	**United States**
Less Than 9th Grade	6.40%	5.90%
9th to 12th Grade, No Diploma	12.10%	8.00%
High School Graduate (includes equivalency)	30.50%	28.10%
Some College, No Degree	22.70%	21.20%
Associate's Degree	8.10%	7.80%
Bachelor's Degree	12.80%	18.00%
Graduate or Professional Degree	7.30%	10.80%

Mississippi ranks last in most categories regarding educational quality and attainment in the nation. In the 2015 Education Week's Quality Counts report, Mississippi rates 51st among the states and Washington, D.C., in K-12 achievement. In 2012, one of every five youth ages 6-17 repeated a grade level at least once (compared to the U.S. average of 11%). Mississippi's on-time graduation rate is 62% (U.S. average is 75.5%). Additionally, an estimated 13% (16,000) of children 16-19 and 23.3% (73,000) of youth ages 18-24 are not in work or enrolled in school; 42% of the age group 18-24 are enrolled in or have completed college (U.S. average is 48%).[2]

GED Testing

Mississippi has a population of 537,920 adults without a high school credential. In 2013, 12,549 Mississippi residents completed the GED Test, with 6,196 or (55%) obtaining passing scores and a high school credential. The largest population of Mississippi candidates to take the GED test is TAY ages 16-24 (66.4%).

Mississippi GED Test Candidates by Age Group

Age	Rate
16-18	32.40%
19-24	34%
25-29	11.70%
30-34	8.90%
35-39	5.20%
40-49	5.10%
50-59	2.20%
60+	0.50%

GED Testing Service 2012-2013 Annual Statistical Report

Impact of Education

Statistics by the U.S. Census Bureau show a tremendous correlation between educational attainment and salary in the state of Mississippi. The trend of possessing a greater educational attainment and earning a larger income is consistent in Mississippi and throughout the United States.
Findings also indicate that individuals with higher levels of educational attainment are generally healthier and feel better. Education also serves as a channel for knowledge and skills development and is pivotal in instilling community principles and acceptable social and behavioral standards. [25]

Education indirectly impacts the level and frequency of various social issues such as teen pregnancy. Couples that are more educated generally have a greater awareness of the financial and psychological repercussions related to child rearing. In addition, education increases a couple's ability to effectively communicate, encourages the belief of self-control an individual has on their life (including how and when to have children), and increases income potential. [25]

Teen Pregnancy

According to the U.S. Department of Health and Human Services, Mississippi was ranked 3 out of 51 (50 states + the District of Columbia) on 2012 final teen births rates among females aged 15-19 (with 1 representing the highest rate and 51 representing the lowest rate).

The Mississippi State Department of Health revealed that during 2013, 5,460 teen pregnancies occurred, or every 49.1 out of 1000 female teenagers. Females under the age of 15 accounted for a rate of 1.6 (167 cases), though TAY ages 15-19 accounted for a rate of 62.7 (6,928 cases), the third highest rate in the nation.[26]

Number of Births to Females under 20 years of Age, Mississippi, 2012

Total	Mississippi	United States
Females under 20 years of age	4,872	309,060
Females aged:		
Under 15	91	3,672
15-17	1,348	86,423
18-19	3,433	218,965
15-19	4,781	305,388
Percent by Mother's Race/Ethnicity	**Mississippi**	**United States**
Non-Hispanic White	42%	39%
Non-Hispanic Black	55%	23%
American Indian or Alaska Native	1%	2%
Asian or Pacific Islander	*	2%
Hispanic	3%	34%

2012 Mississippi Adolescent Reproductive Health Facts, U.S. Department of Health and Human Services

During 2012, White females accounted for 42% of teen birth rates and non-Hispanic Black females accounted for 55% of teen birth rates. Teen pregnancy in Mississippi is highly correlated with the education youth attain regarding safe sex and their ability to employ the necessary methods of prevention.

In 2013, the Youth Risk Behavior Survey found that 35% of Mississippi high school students did not use a condom during sex, 85% did not use a birth control pill, 95% did not use an intra-uterine device (IUD)/implant/ring, and 11% did not use any contraceptive method.[6]

Teenage pregnancy is often associated with negative outcomes as it involves rearing a child at such a young age. However, the benefits associated with the reduction of teen pregnancy extends to a much broader scope of issues. Such benefits include the following[27]:

- Healthier babies, since teen mothers are more at risk of premature birth;

- Greater academic success due to lower female dropout rates (teen pregnancy is the leading cause), and because teenage mothers are 50% more likely to repeat a grade level or score lower on standardized exams;
- Safer communities, as the sons of teen mothers are twice as likely to end up in prison (even compared to mothers who were 20-21 years old);
- Stronger families due to the lesser likelihood of child abuse and neglect that occur at a greater rate with teenage mothers;
- A break in generational poverty: children born to teenage mothers are more likely to be raised in poverty, to be poor as adults, and to become teen parents themselves compared to children not born to teen mothers; and
- Greater tax revenues available that can be allocated to other community needs. U.S. Taxpayers contribute approximately $9 billion yearly to teen childbearing costs such as health care, foster care, and greater levels of incarceration from sons of teen mothers.

XPand Counties Teen Pregnancy Rate Table, Mississippi State Department of Health, 2012

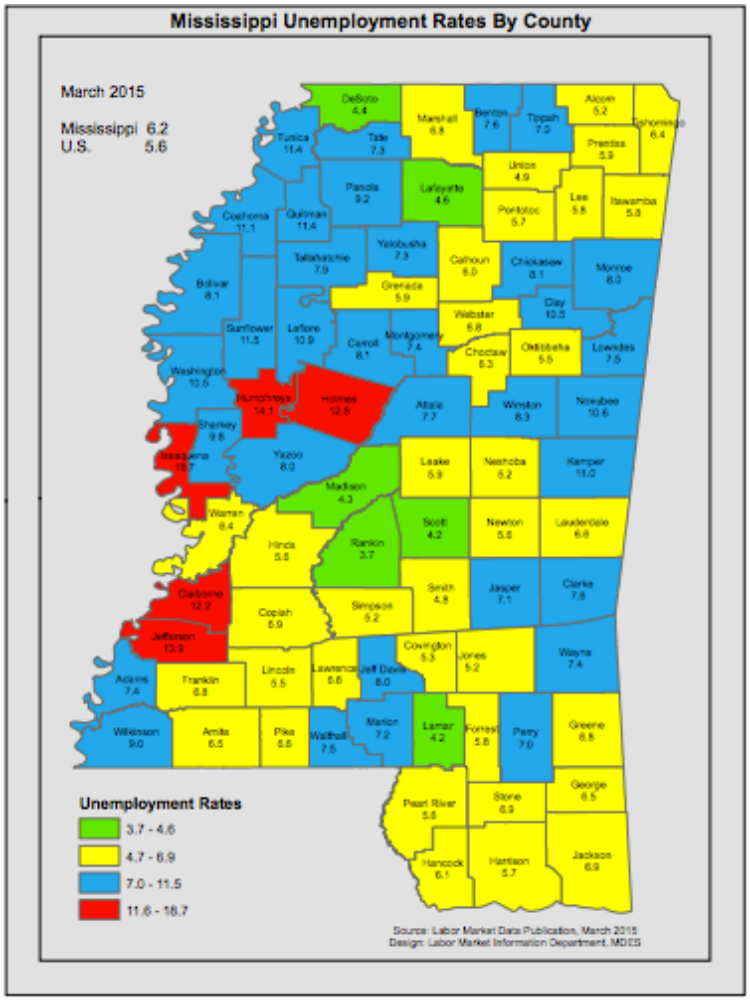
County	Total Births	Age 10-14	Age 15-17	Age 18-19
Clarke	20	3	3	14
Jasper	30	2	7	21
Kemper	14	0	3	11
Leake	41	2	10	29
Neshoba	59	0	20	39
Newton	41	0	11	30
Scott	71	0	15	56
Smith	29	0	3	26

Teen mothers are far more likely to drop out of school than other female youth. Teen mothers often resort to leaving school and/or their job in order to take care of their children, which in turn deprives them of a fundamental educational and work experience background. Thus, teen mothers are at particularly high risk for unemployment and poverty.[27]

Unemployment in Mississippi

The state of Mississippi contained 1,283,200 civilians (16 and older) in the labor force as of October 2013, 109,200 of which are unemployed, creating an overall adjusted unemployment rate of 8.5% (United States at 8.1% for 2013).[30]

Impact of Unemployment



Unemployment rates in Mississippi place a huge damper on a community already suffering from economic and health strife. Research shows that medical conditions such as hypertension and diabetes may ensue the loss of a job, in addition to joint and body aches.[31] Such health issues may be attributed to the lack of physical activity and the potential for binge eating.

The unenthused attitude unemployment may incur on an individual's life may not only be a short-term lapse of morale. According to Diane Lang, a psychotherapist, people who are unemployed for six months show psychological signs of depression. In fact, research also shows unemployment doubles an individual's chance of having a major depressive episode.[31] Along with the prevalence of food binging, individuals often suffer from high amounts of stress and anxiety which make sleep difficult, leading to constant fatigue and exhaustion. It is also common for unemployed persons to feel ashamed or embarrassed regarding their situation, thus social isolation and strains on intimate relationships are expected.[31]

Residents in Mississippi suffering from unemployment are inevitably subjected to the immense stress and pressures of attaining/re-attaining a living income, as well as a sense of purpose and responsibility. Not coincidentally, unemployment is inversely proportional with educational attainment, in which rates of unemployment greatly decreased as educational attainment increased according to research by the United States Census Bureau.[32] Higher levels of education allow individuals greater marketability and knowledge in the workforce.

Youth Unemployment Rate

Recent detailed records regarding youth unemployment are scarce. The most recent categorized accounts of the youth unemployment rates were during 2012.

Results showed that in 2010 the TAY (ages 16-24) national unemployment rate was 16.1%, according to the Bureau of Labor Statistics. Mississippi recorded the highest youth unemployment rate (23%) for the age 16-24 population in the U.S., followed by South Carolina (22.9%), Georgia (20.6%), and California (20.2%).

Homelessness/Out-of-Home Placement of Youth in Mississippi

Out of Home Placement. In 2010, 3,582 children were in out-of-home care, 1,357 were children under age 6, while 701 were age 16 and older.[34] Nearly 24% (843) awaited adoption, and 355 children were legally adopted. Of the 3,582 children in out-of-home care, 41.5% were African-American, 54% were White, 1.9% were Hispanic, and 41.5% were of more than one race. Some 2,305 children exited out-of-home care in 2010, 57.3% of whom were reunited with their parents or family.[35]

Homelessness. In 2010, there were 12,929 homeless children in Mississippi.[36] These homeless were described as under 18 who are accompanied by one or more parent/caregiver, thus it does not include runaways, etc. The state was ranked 49th out of the 50 states by the National Center on Family Homelessness. The rank was determined by 1) extent of child homelessness, 2) risk for homelessness, 3) child wellbeing, and 4) state policy and planning rank. The following are the state ranks in each category[36]:

- 25th in child homelessness with a total of 12,929 children;
- 47th in risk for homelessness. The state minimum wage is $7.25 an hour, while the income needed to afford a two-bedroom apartment is $12.74 an hour; 27% of households pay more than 50% of income for rent; 13.4% children are without health insurance; the 5 year average for children in poverty is 30%;
- 47th in child wellbeing. Nearly 20% of children in poverty have one or more chronic conditions, nearly 15% have asthma, and over 5% have attention deficit disorder (ADD) or attention deficit hyperactivity disorder. 7% of households in poverty have very low food security;
- 50th in state policy and planning. There are only 94 emergency shelters for homeless families, 92 transitional housing units, and 21 permanent supportive housing units. There is no housing trust fund, no state planning efforts such as a Interagency Council on Homelessness (ICH) or a State 10-year plan that includes children and families.

Impact of Homelessness

Homeless children go hungry at twice the rate of other children and are sick four times more often. In addition to the multitude of acute and chronic physical health problems they suffer such as asthma, homeless children have three times the rate of emotional and behavioral problems. Due to the lack of a consistent and qualified learning environment, homeless children are four times more likely to have a delayed development and twice as likely to have a learning disability.[36]

Homeless Programs such as the Mississippi Campaign to End Child Homelessness stress the need for a strong, fully-funded continuum of housing options and services for children and families. Resources need to be allocated carefully and efficiently in coordinated areas in order to assure no child is ever truly homeless on any given night.[36]

More numerous and higher quality facilities that accommodate youth and their families are critical for Mississippi. Impoverished residents in the state are often born with the tremendous disadvantage of living in poverty, which as statistics dictate, lead to untreated conditions such as behavioral issues in TAY, a higher potential for juvenile incarceration and teen pregnancy, a strong inevitability for school dropout/lower level of educational attainment amongst TAY, increased rates of infectious disease in TAY, higher rates of unemployment, and ultimately a great risk for homelessness. The vicious cycle that plagues so many Mississippians and TAY in particular requires a substantial system of support and focus to address and eradicate disparities and disproportionalities.

Part II: Behavioral Health Disparities Impact Statement

A. Subpopulations in the Proposed Geographic Region

Community/Jurisdiction of Focus

XPand will serve several of the following eight Counties of Mississippi: Leake, Kemper, Neshoba, Scott, Jasper, Smith, Newton, and Clarke.

	Leake	Kemper	Neshoba	Scott	Jasper	Smith	Newton	Clarke
Population	23,805	10,456	29,676	28,264	17,062	16,491	21,720	16,732
Ages 0-5	8.0%	6.7%	8.4%	8.1%	6.5%	6.8%	7.0%	6.5%
Ages 0-18	30.9%	23.3%	28.7%	27.0%	24.2%	25.8%	26.0%	24.7%
Ages 65+	13.0%	15.6%	13.5%	12.4%	16.0%	15.3%	14.9%	16.4%
Female	48.1%	51.1%	52.0%	51.1%	51.8%	51.3%	52.1%	52.4%
White/Caucasian	49.5%	35.3%	60.6%	53.3%	46.3%	75.8%	63.2%	64.2%
Black/African American	40.6%	60.1%	20.9%	37.5%	52.6%	22.9%	30.2%	34.4%
American Indian/Alaska Native	6.0%	3.7%	16.2%	0.3%	0.1%	0.1%	5.0%	0.4%
Asian	0.2%	0.1%	0.3%	0.2%	0.1%	0.1%	0.2%	0.2%
Hispanic/Latino	4.3%	0.5%	1.6%	10.7%	0.8%	1.2%	13.0%	0.8%
White/Non-Hispanic	48.8%	35.1%	60.0%	50.8%	46.0%	75.3%	62.6%	63.8%
Language other than English spoken at home	7.5%	4.1%	11.0%	9.2%	0.9%	1.1%	5.1%	0.8%
Below Poverty Level	22.8%	28.3%	28.3%	22.2%	18.6%	19.5%	17.0%	23.1%

The demographic and socio-economic makeup of this area provides an accurate sample of Mississippi statewide. 1,991 youth and young adults between the ages of 14 and 21 with SED received services from Region 10 Community Mental Health Center in this catchment area. The initiative funded team will partner with an existing System of Care site to provide on the job training for CMHC clinicians and direct service providers.

There are an estimated **25,879 - 33,273** youth/young adults in Mississippi that meet the target population requirements (MDMH state plan, 2015) [Based on the 1998 CMHS prevalence methodology for estimating 18-21 year olds with SED, adjusted for MS specific socio-economic issues, and applying the same prevalence methodology to the 2006 census estimates for 16-17 year olds in MS., or 212,000 pop. x 9.2% prevalence rate].

To identify the most accurate and relevant estimate for racial and ethnic representation in this group, we examined statistics from the existing Transitional Outreach Program in MS (MTOP/NFusion) that currently serves this same target population. These percentages should be reflective of the state as a whole. In 2015, **80%** of the total population served by MTOP/NFusion were African American, **16%** were Caucasian, and **2%** were Hispanic.

For the eight county XPand catchment area, the following chart shows the race/ethnicity breakdown of youth 14-21 that received services from Region 10 in the last year.

County_____ Race/Ethnicity	Clarke	Jasper	Kemper	Leake	Neshoba	Newton	Scott	Smith	Total	Percent Of Youth
Black/African – American	70	43	46	83	46	58	92	30	**468**	**53.36%**
White/Caucasian	32	10	13	55	79	82	63	42	**376**	**42.87%**
Native American	1	0	0	0	3	2	0	0	**6**	**0.68%**
Asian/Pacific Islander	0	0	0	0	1	0	0	0	**1**	**0.11%**
Mexican	0	0	0	1	0	0	4	0	**5**	**0.57%**
Puerto Rican	0	0	0	1	0	0	0	0	**1**	**0.11%**
Other Hispanic	0	0	0	0	0	1	1	1	**3**	**0.34%**
Not of Hispanic Origin	105	53	59	141	131	144	156	72	**861**	**98.18%**
Other	2	0	0	3	2	3	6	1	**17**	**1.94%**

Again, using MTOP as a reference point, we can expect the target population to be evenly split between genders (55% male and 45% female), **13%** will likely have graduated high school, **41%** will likely have dropped out of high school, **7%** will likely have been expelled from school, **34%** will likely have been suspended from school, **19%** will likely have been in the juvenile justice (or adult) justice system, **19%** will likely be diagnosed with a substance abuse/dependence disorder, and **2%** will likely be pregnant.

According to the Annie E. Case Foundation 2014 Kids Count, **32%** of children in Mississippi live in poverty (income below $23,283 for a family of four in 2014) compared to 18% for the national average. Additionally, **45%** of the state's children live in single-parent families compared to the national average of 32%. Mississippi also **ranks 50th** for persons aged 18-24 for not attending school, not working, and no degree beyond high school in 2013 (Annie E. Casey Foundation, 2014).

As evidenced by the chart below, many youth ages 18-20 do not continue to receive services or transition to adult mental health services even though they still need treatment:

Youth/Young Adults Served in FY 2014 by Mississippi CMHCs

Age	Number Served
9-21 years	34,194

Source: Mississippi State Plan for Community Mental Health Services Implementation Report, FY2014

Children's mental health services clients are most likely to be referred by family and friends (28%) or educators (27%) (Banks & Pandiani, 1998). Therefore, as transition-age youth strive to establish independence from the caregivers and other adult authority figures in their lives, it is not surprising to see the precipitous drop in the number of youth who choose to participate in these services after they turn 17 (the year they can choose to drop out of school), and even more so after they become 18 (the year the State deems them to be adults). However, youth who distance themselves from social supports generally have difficulty successfully transitioning to adulthood (Dahl & Spears, 2004).

According to Dahl & Spears (2004), achieving adult status requires developing self-control of behaviors and emotions, specifically:

- Appropriately inhibit or modify behaviors to avoid negative future consequences;
- Initiate and persist sequential steps toward goals;
- Navigate complex social situations despite strong affect;
- Self-regulation skills of affect and complex behavior to serve long-term goals; and
- Involves neurobehavioral systems in PFC (prefrontal cortex).

Youth who do not have this self-control or adults to help them gain it are at great risk for poor outcomes. The plight of youth with serious emotional disturbance in transition to adulthood is grave. As a group, these youth are undereducated, underemployed, and have limited social supports. Drug and alcohol abuse are common, and suicide risk is high. These youth remain largely "unclaimed," falling through the cracks within and between the child and youth service systems.

Youth without families who are meaningfully involved in their lives are at most risk. Some of these youth are in State custody. Of the 5,676 youth who were in the custody of the Department of Human Services for child abuse and neglect or unmanageable or delinquent behavior in 2007, only 971, or **17%**, also received mental health services (MS Dept. of Human Services, 2007).

The education system in Mississippi should also be a source of referrals. The statewide dropout rate for students is 15.9%. For students with SED, however (many of who are in special education), the rate jumps to nearly **24.4%**, or 2,980 youth. Dropping out is often a precursor to unemployment and/or incarceration (MS Dept. of Education, 2007-2008).

Youth and/or young adults returning from an institutional setting, such as a psychiatric hospital or detention center/jail, will certainly need supportive transitional services to return to the community and successfully function in society.

Nearly **34%**, or 218, of youth with SED in Mississippi have been hospitalized and/or incarcerated (MDMH, URS, 2007).

The primary service disparity for youth with mental health and other needs is a result of the gap or lack of an integrated transition from children services to adult or age appropriate services when a youth reaches 18. Service models have not been adequately tailored to meet the differing needs of this transition-age person. A second disparity is the gap or lack of integrated transition from an institutional setting back to the community and from state custody (foster care) to independence. A third disparity for youth with mental health needs is location. Like most rural, poor states, there is a substantial difference between the accessibility and quality of available services and supports in rural areas of the state compared to those in the few urbanized areas in Mississippi.

In FY 2011, 40,297 youth, 0-20 years, received mental health services in MS. 40% were identified as White, 47% were identified as Black of African American, and 3% Asian or American Indian (MDMH, URS Table 2A, 2011). According to the Annie E. Casey Foundation (2009), of the youth 0-18 years of age of MS, 50% are White, 44% African American, 3% Hispanic, 1% Asian, and 1% American Indian.

There is obvious and substantial room for improvement in service delivery and outcomes for youth in transition. The proposed project is designed to address each of these identified disparities in service.

Number of Individuals to be Served

The XPand project will serve an average of 100 participants annually over the 3 ½ - year implementation period, or a total of 350 youth and young adults, ages 14-21, with SED who are transitioning from child mental health services to adult mental health services and/or from an institutional setting to the community.

B. Addressing Race, Ethnicity, and LGBT Status

Data Collection Activities

The following table outlines major program goals for this initiative, sources of formal quality assurance data, and performance measures that will be reported at monthly project meetings and in reports to SAMHSA:

Required Activities	Data Sources	Performance Measures
Provision of mental health services	CMHS Child Outcome Measures for Discretionary Programs (Child or Adolescent Respondent Version and Caregiver Respondent Version)	- Mental illness symptomatology; - Employment/education - Crime and criminal justice; - Stability in housing; access, i.e., number of persons served by age, gender, race and ethnicity; - Rate of readmission to psychiatric hospitals;

		- Social support/social connectedness; and - Client perception of care.
Engagement in outreach activities	Sign-in sheets, social media and marketing analytics	- The number of individuals exposed to mental health awareness messages.
Services are delivered within a family-driven, youth-guided framework and how families and youth will be integrally involved in the governance and oversight of grant activities	NOMS, locally developed CQI forms	- The number and percentage of work group/advisory group/council members who are youth/family members
Expansion of family and youth involvement, and demonstration that youth and families are integral partners in planning and implementation activities	Sign-in sheets, youth engagement surveys	- The number of youth/family members representing youth/family organizations who are involved in on-going mental health-related planning and advocacy activities as a result of the grant - The number of youth/family members who are involved in mental health-related evaluation oversight, data collection, and/or analysis activities as a result of the grant
Collaborations across child serving agencies (e.g., child welfare, juvenile justice, primary care, education, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings. Collaboration between child and adult serving agencies are critical when serving older youth who are transitioning to adulthood.	Social network analysis	- The number of agencies/organizations or communities that demonstrate improved readiness to change their systems in order to implement mental health-related practices that are consistent with the goals of the grant - The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant
Integration between mental health and substance abuse services and systems.	Formal, written agreements; measures focused on collaboration across agencies	- The number of agencies/organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/ MOAs) to improve mental health-related practices/activities as a result of the grant
Creation of outcome measurement strategies based on SOC values and	CMHS Child Outcome Measures for Discretionary	

principles that are aligned with State/Tribal/Territorial efforts and identification of electronic health records and data management approaches.	Programs (Child or Adolescent Respondent Version and Caregiver Respondent Version)	
Coordination of SOC strategies with block grants and other health care reform efforts.	Sign-in sheets; CQI questionnaires	- Number of agencies/organizations involved with governance council structures, strategic planning meetings, etc.
Critical collaborations with substance abuse, wellness promotion, and illness prevention activities.	MSSC	- Number of agencies/organizations involved with youth in case plans
Incorporation of trauma-related activities into the service system, including trauma screening, trauma treatment, and a trauma-informed approach to care.	Progress reports	- Staff and youth will be trained in trauma-informed approaches to care
Development of social marketing and strategic communications activities to promote social inclusion, develop partnerships, and promote system of care values and principles.	Progress reports	- Agencies and communities will be aware of system of care principles
Creation of sustainable training and technical assistance strategies that facilitates ongoing learning, coaching and practice improvement, and supports fidelity to SOC values and principles.	Progress reports	- A change made to a credentialing and licensing policy in order to incorporate expertise needed to improve mental health-related practices/activities as a result of the grant
Development and subsequent implementation of a strategic financing plan that incorporates Medicaid and other third party payors, other child serving agencies and systems, and block grants; thereby creating a mechanism for the SOC framework to be brought to scale and sustained.	Strategic Financial Plan	- The amount of additional funding obtained for specific mental health-related practices/activities as a result of the grant - The amount of pooled/blended or braided funding with other organizations used for mental health-related practices/activities as a result of the grant
Development of statewide/tribal/territorial interagency coordination	Social Network Analysis	- The number of agencies that the lead agency coordinates with as a result of this project

and collaboration mechanisms that clearly support an infrastructure to increase the focus on wide scale adoption of SOC, including an organizational structure that identifies a locus of authority and responsibility, and ability to provide oversight of the SOC (e.g., Statewide/tribal/ territorial Interagency SOC Expansion Implementation Board).		
Establishment of policy, administrative and/or regulatory structures that support ongoing SOC implementation efforts.	Progress reports	- The number of policy changes completed as a result of the grant - The number of financing policy changes completed as a result of the grant

Program Services/Activities

The overall purpose of this initiative is for Mississippi's transitioning youth with SED to have the necessary family and youth driven supports and structure to be prepared for independent living and to be productively engaged in the community, to establish a System of Care (SOC) driven model for community mental health centers, and to collaborate with existing state agencies, such as Medicaid, to implement SOC based policies and legislation.

The project goals are to achieve the following:

- Expand community capacity to serve transitional age youth;
- Provide a broad array of accessible and coordinated services/supports;
- Ensure individualized, managed care;
- Plan, deliver, and evaluate these services with the full participation of families and youth in a culturally and linguistically sensitive manner; and
- Facilitate broad-based, sustainable systemic support for the target population.

Measurable Objectives include the following:

- Improved social and clinical functioning outcomes;
- Decreased caregiver strain;
- Improved educational events and outcomes;
- Fewer juvenile justice and/or adult justice system incidences;
- Enhanced employment skills and opportunities;
- Fewer out-of-home placements; and
- Stable housing situation.

a. Facilitate provision of an array of individualized, culturally and linguistically competent mental health and appropriate recovery support services (consistent with sections 561- 565 of the Public Health Service Act, as amended) and creation of workforce development activities, including the incorporation of parents/caregivers and youth with lived experience in the workforce.

The services provided will reflect the cultural and linguistic context preferred by the youth and their family. The individual service plan will be developed with the family. The plan will be developed in an honest, trustworthy, and culturally sensitive environment that will be consistent with the family's cultural context including using the family's preferred language; building upon the family's own beliefs, practices, traditions, customs and behavioral norms; affirming each child's and family's inherent strengths and resiliency; and utilizing a natural network and support.

XPand will also centralize around a Wraparound philosophy. Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. Wraparound has been described as a philosophy, an approach, and a service. It is most commonly conceived as an intensive, individualized care planning and management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis of integrating the youth into the community and building the family's social support network.

XPand will also use Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT), an evidence-based model designed to address the needs of children and families at risk for child physical abuse, was developed by Melissa K. Runyon, Ph.D. in collaboration with Esther Deblinger, Ph.D. CPC-CBT has been identified by the National Child Traumatic Stress Network as a promising practice and is currently under review for inclusion in the National Registry of Evidence-Based Practices.

b. Assure that services are delivered within a family-driven, youth-guided framework and how families and youth will be integrally involved in the governance and oversight of grant activities.

One of the partners for MTOP service delivery sites (NFusion) is the local Federation of Families chapter. This organization works to develop partnerships

and leadership skills with family members and between families and professionals by involving them at all levels of System of Care activity.

Families (consumers of services) have been active at all governance levels in Mississippi's initiatives (i.e., MTOP service delivery sites). They take part in planning, guiding service delivery and advising around adherence to SOC and Wraparound principles and values through participation in Executive committees and on task groups such as Clinical/EBP; Social Marketing; Cultural & Linguistic Competence; Evaluation, etc. In addition, they have initiated Family Advisory Councils to give important feedback on SOC outcomes to staff and community partners. We expect opportunities to occur in the XPand initiative.

Hiring of Staff: Current SOC projects include family members and youth who participate in the hiring interviews for SOC staff. These individuals will be available to assist with hiring for XPand.

Direct Service Provision: For the previous SOC projects, the family organization has worked with family participants to provide direct services to enrolled families and their children through the following programs:

- Certified Peer Support Specialists: NFusion Family Engagement Specialists who are Certified Peer Support Specialists provide peer-to-peer information and support to families of children and youth with SED. These individuals will support parents in XPand to become Family Driven in their "voice and choice" with their individual child's care and in system reform that will continue to occur in XPand and in the statewide MS System of Care (MTOP/NFusion).
- Respite Care: The respite care component has been well-developed and implemented in parts of the state by the Federation of Families chapter over the last 16 years. XPand will coordinate with the local MAP teams to contract with respite providers in their catchment area.
- Family Education/Support: Both organizations providing training and continuing education for families of children and youth with SED. Another SOC partner, the National Alliance on Mental Illness (NAMI), engages parents in its Parent-to-Parent education classes and its most recent program, NAMI BASICS.

c. Development of statewide/tribal/territorial interagency coordination and collaboration mechanisms that clearly support an infrastructure to increase the focus on wide scale adoption of SOC, including an organizational structure that identifies a locus of authority and responsibility, and ability to provide oversight of the SOC.

Statewide working groups will include the Statewide Affinity Group (SWAG), Interagency Coordinating Council for Children and Youth (ICCCY), and Interagency

System of Care Council (ISCC), and MAP Teams/A Teams. Cross-system representation that includes executive-level members from the state's public education, Medicaid, mental health and other service systems ensures that collaborative opportunities for funding sustainability are identified.

ICCCY is required to meet at least twice annually, lead the development of a statewide System of Care, oversee the annual pool of funds for the System of Care, and monitor the development of Multidisciplinary Assessment and Planning (Make a Plan or MAP) Teams.

HB 1275 also created the Interagency System of Care Council (ISCC) consisting of a member of each state agency representing the ICCCY team, a family member representing a family education and support organization, two special education organization representatives, and a family member appointed by Families as Allies.

ISCC serves as the management team for ICCCY with the following responsibilities:

- Collecting and analyzing data and funding strategies;
- Searching and applying for grants from public and private sources;
- Making recommendations to the ICCCY and to the Legislature;
- Coordinating local Make A Plan (MAP) Teams and A Teams; and
- Requiring participation on MAP Teams and A Teams at the county level.

The MAP Teams that were established in this statute consist of members representing local education, human services, health, mental health, and rehabilitative services, and three additional members, one of whom can represent a family education/support organization with statewide recognition. While not required, the mental health representative from the local Community Mental Health Center often serves as the MAP Team Leader. The MAP Teams serve several functions with the primary purpose of diverting children and youth from inappropriate institutional placement:

- Review cases concerning children and youth up to 21 years of age who have serious emotional disorder (SED) or serious mental illness;
- Develop a service plan that may include existing services and informal supports/services; and
- Monitor and track implementation o the plan and status of the child.

The ISCC provide input to the ICCCY and vice versa relative to how the agency utilizes federal and state statues, policy requirements and funding streams by

- Supporting the implementation of the plans of respective agencies;
- Overseeing a pool of state funds that may be contributed by each state agency;
- Facilitating the monitoring of the performance of MAP Teams; and

- Developing a MOU outlining responsibilities to be signed and in effect by July 1st of each year.

d. Establishment of policy, administrative and/or regulatory structures that support ongoing SOC implementation efforts.

The WEEMS Region 10 Community Mental Health Center will implement standards of care for community mental health services to promote the system of care philosophy for other mental health centers to replicate. These include, but are not limited to; youth driven care, family driven care, culturally and linguistically competent services, Evidence-Based Practices, and community collaboration. The cross agency collaboration of the ICCCY and ISCC will generate real policy and regulation at the service delivery level.

e. Expansion of family and youth involvement, and demonstration that youth and families are integral partners in planning and implementation activities.

Financial Support: As with past SOC awards, WEEMS will use funds from the XPand initiative to support family and youth activities such as:

- Specialized training and ongoing consultation with project staff, MAP Teams and local enrollees on implementation of Family-Driven and Youth-Guided care;
- Development and coordination of local Family Advisory Councils and Youth Advisory Councils;
- Employment and contracts with family peer support and youth peer support specialists; and
- Training and coordination for local respite providers.

Stipends and Incentives: The local Federation of Families chapter wrote revised policies and procedures for providing stipends to families and youth to enable their participation in all aspects of the development, implementation, evaluation and sustainability of the previous SOC initiatives (MTOP/NFusion). These policies strictly adhere to SAMHSA's requirements for non-coercive compensation and were approved in the fall of 2008. In no instance does the value of the incentive paid through SAMHSA grant funds exceed $20.

Evaluation: In all of the SOC communities, family members were trained to perform all aspects of the local and national evaluation, including administration of instruments and family and youth interviews. In addition, the Turnaround Achievement Network provides evaluation services to facilitate youth and family evaluation and service satisfaction feedback. Local SOC Family Advisory Councils have and will provide feedback to governance committees and task groups on service quality, cultural and linguistic competence, needed services and fidelity to Wraparound principles and values in the XPand initiative.

Peer Support Specialists: In July 2012, Peer Support Services was added as a Core Service for DMH's Certified Providers. Since February 2013, there have been 7 Certified Peer Support Trainings. Family and youth peer support specialists have already been hired at WEEMS's current NFusion sites and will continue to play an integral role in service delivery and planning. WEEMS is committed to ensuring that peer specialists are trained to provide expertise in all areas of care for the XPand initiative.

f. Collaborations across child and youth serving agencies (e.g., child welfare, juvenile justice, primary care, education, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings.

A primary purpose of the Interagency Coordinating Council for Children and Youth (ICCCY), established in 2001, is to promote and ensure collaboration among the other child-serving agencies. There are current MOU's among agencies that identify the commitment and role of each agency regarding the collaborative care and support of children and youth with SED. At the next level, the Interagency System of Care Council (ISCC), composed of mid-level management personnel with each agency, is where the actual service coordination takes place. A new governance body for the initiative will be developed to advise and facilitate the planning and implementation of this project. Working through project staff, this body will keep local entities and families aware of and connected with other relevant federal and state initiatives.

Further, this initiative will include the Department of Human Services, State Dept. of Education, State Health Dept., State Dept. of Rehabilitative Services, and the Division of Medicaid through the MOU's described earlier for collaborative planning and service delivery to the target population and by agency representation on the MAP Teams. Families as Allies, the primary family support organization in the state, is a member of the ICCCY and has representation on the MAP Teams as well.

g. Collaboration between child and adult serving agencies as well as consumer groups which are critical when serving older youth who are transitioning to adulthood.

This initiative will work closely with federal and state programs, such as: (1) CommUNITY Cares, a former CMHI grant for SOC development in 3 counties in MS; (2) MYPAC, a former CMS waiver and demonstration grant. MYPAC was administered by the Division of Medicaid, a partner with MDMH on this proposed initiative; (3) Transitional Outreach Program (TOP), an existing transitional youth model project funded by MDMH and administered by Pine Belt Mental Health Resources in two of their counties.

The initiative will also work with and utilize the resources provided through the two former National Child Trauma Stress Network grantees, Trauma Recovery

for Youth (TRY) project operated by Catholic Charities and Trauma Informed Disaster Evidenced-based Services (TIDES) operated by Gulf Coast Mental Health.

The XPand initiative will also work closely with the State Wide Affinity Group (SWAG). This group formed out of the MTOP grant and includes the largest number of state agencies, advocacy organizations, and SOC collaborators in Mississippi with over 75 members. This group meets quarterly to share resources across fields and expand knowledge of the system of care philosophy.

h. Integration between mental health and substance abuse services and systems.

The MDMH houses both the Bureau of Community Services and the Bureau of Alcohol and Substance Abuse Services, including staff from both for all of MDMH strategic planning. In addition, the local MAP teams at every community mental health center include providers from the alcohol and substance abuse services arena. Each of the governance structures at previous SOC sites also include coordinators and supervisors of local substance abuse treatment programs. The State Wide Affinity Group (SWAG) that provides knowledge transfer to all state agencies also includes 8 members from different substance abuse programs across the state.

The SWAG serves as the Advisory Council for this grant. CMHCs Region 2 and 12 received sub-grants from the Mississippi Department of Mental Health (DMH) to improve assessment and treatment services for adolescents with co-occurring substance abuse and mental health disorders through the use of a $3.8 million, four-year grant from the Substance Abuse and Mental Health Services Administration. The Mississippi State Adolescent Treatment Enhancement and Dissemination (MS SYT-ED) project will strengthen the State's systems to serve adolescents, ages 12 – 18, with co-occurring substance use and mental health disorders by developing two learning sites in Mississippi for evidence-based treatment for adolescents. The two learning sites will help develop a blueprint for policies, procedures, and financing structures that can be used to widen the use of evidence-based substance abuse treatment practices in Mississippi. The two learning sites will identify barriers to access and treatment, and test solutions that can be applied throughout the state for adolescents and their families. Anticipated outcomes of the MS SYT-ED project include the following:

- Decreased juvenile justice involvement for adolescents;
- Increased rates of abstinence;
- Increased enrollment in education, vocational training and/or employment;
- Increased positive social connectedness; and
- Increased access, service use, and outcomes among adolescents most vulnerable to health disparities.

WEEMS will be included in the training opportunities from the MS SYT-ED, which will include different versions of the Global Appraisal of Individual Needs (GAIN) as the assessment tool and Adolescent Community Reinforcement Approach (A-CRA) as the behavioral intervention.

i. Creation of outcome measurement strategies based on SOC values and principles that are aligned with State/Tribal/Territorial efforts and identification of electronic health records and data management approaches.

The ICCCY and ISCC along with the MDMH are committed to working with WEEMS to identify measurements not only for this initiative, but as benchmarks for the state. The Turnaround Achievement Network is currently working with Mississippi SOC projects and the state to identify strategies that cross services and effectively evaluate the outcomes for youth and families. Each SOC project uses a universal electronic health record number that ties into that individual's CMHC, Medicaid or other funding source, health charts, and evaluation measures.

j. Coordination of SOC strategies with block grants and other health care reform efforts.

The Mississippi Department of Mental Health has a comprehensive State Mental Health Block Grant Plan, which is also utilized as the Mental Health Plan for Community Mental Health Services. The FY 2009 State Mental Health Plan for Community Mental Health Services has four objectives pertaining to the State's efforts on serving the transitional–aged youth. The objectives are to achieve the following: (1) Continue development of strategies for enhancing and/or increasing service options for the transitional age youth (14-24) through the Transitional Services Task Force; (2) Continue funding for mental health services for youth in one transitional therapeutic group home and two supported living programs for youth in the transition age group (16–21); and (3) Develop anti-stigma campaign targeted to young adults with serious mental health conditions.

k. Incorporation of trauma-related activities into the service system, including trauma screening, trauma treatment, and a trauma-informed approach to care.

WEEMS current NFusion site and East MS State Hospital/Bradley Sanders Adolescent Complex (an inpatient behavioral center) entered into a Learning Community with the National Council of Behavioral Health. The Learning Community offers individual and group coaching by renowned national trauma experts, webinars, networking opportunities, and exclusive tools and resources. At the end of the year-long Learning Community, participants will be deeply immersed in implementing trauma-informed approaches in their agencies.

The 6 Domains and Performance Standards are as follows:

- Early Screening and Comprehensive Assessment of Trauma;
- Consumer Driven Care and Services;
- Trauma Informed, Educated and Responsive Workforce;
- Trauma Informed, Evidence-Based and Emerging Practices;
- Create Safe and Secure Environment; and
- Engage in Community Outreach and Partnership Building.

Trauma-Informed Care

XPand will continue the Trauma-Informed Care training created by the Mississippi Department of Mental Health (MDMH). MDMH, in conjunction with the Mississippi Transitional Outreach Project (MTOP), State Wide Affinity Group (SWAG) and Turnaround Achievement Network, pilot-tested and rigorously evaluated multiple *Becoming Trauma Informed* trainings. A wide array of attendees were represented including medical staff, first responders, law enforcement, behavioral health providers, consumers of services, youth and family members, educators, advocacy groups, domestic violence, juvenile justice, drug courts, foster care, group homeless, homeless, and social workers.

Information obtained from hundreds of evaluation forms completed by participants at the conclusion of the *Becoming Trauma-Informed* trainings indicated an increased knowledge of four learning objectives. Participants were asked to rate their knowledge from *low* to *high* on the learning objectives *Before* and *After* attending the training. The learning objectives included the following:

1) Identify at least four strategies to reduce the likelihood of re-traumatization;
2) Explore a minimum of two ways trauma affects people developmentally, psychologically, and physiologically;
3) Describe trauma-informed care, identify principles/behaviors of those with trauma histories; and
4) Identify treatment strategies and approaches consistent with trauma-informed care.

Trauma-Focused Cognitive Behavioral Therapy

XPand will continue to support training for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a hybrid treatment model developed by Deblinger, Cohen, and Mannarino that integrates trauma sensitive interventions with cognitive-behavioral strategies [Ester Deblinger, Ph.D. Center for Children's Support, University of Medicine and Dentistry of New Jersey; Judith Cohen, M.D., and Anthony Mannarino, Ph.D., Center for Traumatic Stress in Children and Adolescents, Alleghany General Hospital].

TF-CBT can be used with a range of traumas (traumatic loss/grief, physical abuse, memory of trauma, substantiated or "more likely than not" abuse, and/or diagnosis of PTSD or PTS symptoms. It is time limited and structured for 12-20 sessions. TF-CBT is adaptable and flexible to address developmental issues, gender, initial presentation, etc., respectful of culture, family values, and the therapeutic relationship is central.

Training occurs through a Learning Collaborative approach, which is an adoption and improvement model focused on spreading and adapting best practices across multiple settings and creating changes within organizations that promote the delivery of effective practices.

Screening instruments will be administered when services are initiated. Those that screen positive will be referred to a therapist who is trained in TF-CBT.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

The XPand initiative uses SPARCS to "address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning" (NCTS). Examples include impulsivity, dissociation, numbing and avoidance, and hopelessness. The goals of SPARCS include the following:

- Help teens cope more effectively in the moment
- Enhance self-efficacy
- Connect with others and establish supportive relationships
- Cultivate awareness; and
- Create meaning.

SPARCS is a group-based intervention comprising 16 sessions (1 hour each), and the theoretical basis is grounded in Cognitive-Behavioral Therapy, Dialectical Behavior Therapy, and complex trauma. The key components of SPARCS include mindfulness, problem-solving, meaning making, relationship building, communication skills, and distress tolerance. A review by the National Child Traumatic Stress Network found that this treatment is "appropriate for traumatized adolescents with or without current/lifetime PTSD and can be implemented while adolescents are still living with unstable/stressful environments (NCTSN, 2007).

l. Development of social marketing and strategic communications activities to promote social inclusion, develop partnerships and promote system of care values and principles.

The XPand initiative will include a small portion of its budget for targeted social marketing activities, and the MDMH has agreed to provide in-kind social marketing activities. These activities will operate in conjunction with the state's youth suicide prevention and underage drinking programs.

Mississippi's Youth Suicide Prevention Project will be utilized to support Mississippi in strengthening and implementing statewide youth suicide prevention strategies through collaboration with youth-serving institutions and agencies such as educational institutions, providers of substance abuse prevention and treatment programs, providers of mental health programs, and community based coalitions reaching out to at-risk youth throughout our state. The population of focus will include youth, ages 15-24, throughout MS. The population of focus will also include community level gatekeepers throughout MS. Available, approachable, and accessible community level gatekeepers that blend public and private entities are key to motivating entire communities to take action to prevent youth suicide and promote good mental health. This project seeks to develop broad based support for youth suicide prevention from community level gatekeepers so that prepared

community level gatekeepers are engaged in activities that are coordinated and address strategies outlined in Mississippi's Youth Suicide Prevention Plan.

Additionally, Mississippi seeks to engage youth in planning and implementing youth suicide prevention strategies, particularly those activities that relate to social marketing and conducting information and awareness campaigns through the use of "new media". Mississippi's project will support SAMHSA's goals that include: increase the number of persons in youth serving organizations that are trained to identify and refer youth at-risk for suicide; increase the number of health, mental health and substance abuse providers trained to assess, manage and treat youth at risk for suicide; increase the number of youth identified as at risk for suicide, increase the number of youth referred for behavioral health care services; increase the number of youth at risk for suicide who receive behavioral health care services; and increase the promotion of the Lifeline.

m. Creation of sustainable training and technical assistance strategies that facilitates ongoing learning, coaching and practice improvement, and supports fidelity to SOC values and principles.

The State System of Care (SOC) staff will be responsible for implementing ongoing training and technical assistance for community mental health centers, state agencies, and other community partners. These staff will work with existing SOC services and youth and family partners to ensure appropriate training across the state. By utilizing the SOC model established at Region 10 to implement the XPand initiative, the state will have a training site to allow professionals training in the SOC philosophy to “walk-thru” the services, enabling them to work onsite with individuals providing those SOC services. Once professionals have received orientation and onsite SOC training, State staff will then provide technical assistance to those service providers to continue providing training and follow up. The SOC staff will also be responsible for connecting these providers with experts (e.g. billing, transportation, clinical skills.) at Region 10 and other agencies such as Medicaid to ensure adequate ongoing support.

Data Reporting

Access, Use, and Outcomes Measures

The XPand Program Evaluation conducted by the Turnaround Achievement Network will be comprehensive and rigorous, will reflect multiple levels of analysis, and will assess the impact of project activities across local and statewide systems. Evaluation activities will fully comply with SAMHSA national evaluation requirements, the National Outcome Measures (NOMs) and Government Performance & Results Act (GPRA) data reporting requirements.

Duties, Activities & Procedures

- Rigorously evaluate the initiative with all elements of the GPRA,

National Evaluation Measures (NOMs), CMHS Child Outcome Measures for Discretionary Programs (Child or Adolescent Version and Caregiver Respondent Version), and site visit assessment reviews as well as specific local qualitative and quantitative metrics;
• Implement accurate practices for the delivery of any and all national, state, and local measurement outcomes;
• Establish a functional evaluation workgroup that encompasses staff, youth, and families from every SOC site and other child serving agencies;
• Develop Logic Models that reflect the systems at the state and local levels;
• Develop a Mississippi System of Care/XPand Program Manual and Guide
• Review all current reporting and documentation (e.g., federal quarterly/annual reports, program manuals, evidence-based practice fidelity measures) to assess overall needs and opportunities;
• Provide Strategic Planning for the XPand Evaluation so that overall goals, objectives, activities, person(s) responsible, measures of success, and progress and achievements (benchmarks) are clear to XPand administrators and staff; and
• Conduct advanced CQI methods training for the Evaluation team.

Performance Assessment & Policies & Procedures CQI

The Performance Assessment/CQI Coordinator will evaluate XPand program implementation of policies and procedures and guide quality assurance/continuous quality improvement. These activities will demonstrate a high level of cultural competence by engaging 360-degree input in the QA/CQI design, processes, and analysis.

Duties, Activities & Procedures

• Analyze aggregate performance data, including numbers and demographics served, location of activities, and participant evaluations on a regular and ongoing basis, and inform XPand administrators of the need to implement programmatic CQI changes and staff training as necessary;
• Provide ongoing support to service providers on all System of Care related needs and activities for performance assessment
• Produce a summary of CQI needs and a plan for implementation (action plan);
• Design CQI baseline measurements aligned with SAMHSA SOC guidelines and XPand Strategic Planning / Action Plans;
• Provide in-service training for staff to better understand CQI, the importance of data collection and documentation, and how their input and community needs drive service programming;

• Design and operate online data systems and conduct comprehensive analyses of both quantitative and qualitative information;
• Design, modify and deliver formal and informal technical assistance to ensure data quality, including the use of various forms of computer based and communication technologies, training curricula, and presentation materials; and
• Develop high quality, professional summary reports and presentations by using an information design approach that is focused on conveying abstract information in intuitive ways that allows readers/audiences to see, explore, and understand large amounts of information at once.

Data Analysis & Reporting

The Evaluation Coordinator will work in partnership with the WEEMS Evaluation Associate to achieve the following data analysis and reporting duties:

• Implement the Evaluation Plan for the XPand program and prepare all reports according to timelines defined in the Evaluation Plan;
• Complete all agency and grant required paperwork for quality assurance reports to XPand program administrators and the National Evaluation team;
• Analyze data entered by the WEEMS Evaluation Associate (National Outcome Measures (NOMs), Child Consumer Outcome Measures for Discretionary Programs, and Transformation Accountability (TRAC);
• Assist XPand Evaluators with the development of local materials such as manuals, training materials, participant correspondence, logs, and tracking sheets/checklists to guide local implementation of national and local evaluation efforts;
• Assist the XPand Evaluators with collaborating with agency Information Technology staff to develop procedures for accessing and transferring agency record data on children receiving system of care services;
• Provide regular updates to XPand Evaluators, administrators, and designated staff as well as attend regular supervision meetings;
• Conduct interviews or focus groups with youth and family members for various
evaluation/CQI studies;
• Correspond with XPand program staff to set up CQI interviews/focus groups; and
• Understand and comply with HIPAA regulations and practice rigorous confidentiality and data security procedures.

Data Utilization Support - Social Marketing, CLC, & Training/TA

All Turnaround Achievement Network staff listed herein will provide XPand Staff Support activities that will promote social inclusion, develop partnerships, and promote System of Care values and principles.

Data Support for Social Marketing - Activities & Procedures

• Provide a simple understanding of System of Care values to the public;
• Work with the State Wide Affinity Group regarding data requests;
• Identify professional conferences, venues, and publications (e.g., SAMHSA newsletter) to report XPand achievements;
• Identify opportunities to collaborate with other similar Systems of Care to share efforts and best-practice models;
• Identify opportunities to incorporate integrated behavioral and primary care approaches to serving the needs of youth and families; and
• Share achievements and outcomes via social media.

Data Support for CLC - Activities & Procedures

• Emphasize the importance of Youth and Family CLC/Satisfaction Surveys;
• Analyze and report data from Youth and Family CLC/Satisfaction Surveys;
• Report ongoing updates to CLC staff;
• Receive ongoing updates re: reconciliation counts and potential challenges/resolutions;
• Analyze Combined CLC & Satisfaction Survey data;
• Identify needs and share materials to create a feedback loop with Youth Advisory Board members.

Data Support for Training/TA - Activities & Procedures

• Work with Training/TA staff to provide reports as soon as data are entered/available; and
• Work with Training/TA staff to analyze and report CQI Assessment data.

C. Plan for Policies/Procedures Development

An XPand Program Manual will be developed that will contain the policies and procedures for the initiative. This manual will be developed in partnership with XPand administrators, staff, youth and families.

Alignment with Enhanced CLAS Standards

The Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to achieve the following:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Diverse Cultural Health Beliefs & Practices

XPand staff will use their cultural and linguistic competence regarding the language, beliefs, norms, values and socioeconomic factors of the population of focus. Staff comprise racial/ethnic minorities representative of our clients and staff are members of coalitions and committees in counties that complement our efforts to provide services to the identified target population.

Clients will also provide direct input in assessing, planning and implementing the project. A core component of XPand is the use of peers. A number of former clients actively participate in our substance abuse programs and have been peer volunteers or paid staff members. Volunteer peers have proven to be successful in recruiting youth to prior programs. We will attempt to leverage their credibility and contacts within their community to help identify youth within racial and ethnic minority populations and recruit them to participate in the program. In addition to the use of peers, focus groups and other CQI evaluation methods will be held with participants and a Youth and Family Advisory Boards will ensure that service delivery is culturally appropriate and sensitive to the specific needs of this population.

Structural Change Objectives

The following set of Structural Change Objectives will be pursued by XPand and will be reflected in the initiative's strategic planning, collection and use of data, and Program Manual:

Immediate and Short-Term

Improve Practices, Knowledge, and Engagement

1. Expand safe zones/safe spaces for *all* youth, including racial/ethnic/LGBTQI2-S minority youth
    a. Receive safe zone training
    b. Designate safe zone areas (e.g., meeting rooms, common areas)
    c. Support individual personnel who self-identify as allies and promote safe zones
2. Identify training opportunities on selected topics related to disparities and disproportionalities (e.g., homelessness, suicide prevention, bullying)
    a. Schedule on-site learning events
    b. Disseminate online webcast/webinar resources
3. Share learning content with service systems, programs, providers, and caregivers connected to the system of care (e.g., Foster care families, schools, faith-based organizations)
4. Develop support group space or referrals for racial/ethnic/LGBTQI2-S youth and families
5. Partner with racial/ethnic/LGBTQI2-S community alliances
6. Identify local racial/ethnic/LGBTQI2-S inclusive treatment success stories
7. Provide self-assessment tools and resources for system of care staff to evaluate their level of comfort, acceptance, or stigma for working with racial/ethnic/LGBTQI2-S youth and families

Long Term

Improve Capacity Building and Sustainability

1. Conduct an anti-discrimination policy review to determine whether policies include race/ethnicity/sexual orientation and gender identity
    a. Review employment policy (e.g., Can staff who are allies feel safe to be out at work or provide support at work?)
    b. Examine partner agency policies (e.g., those providing and receiving referrals)
    c. Incorporate service inclusion requirements into vendor contracts
2. Conduct asset mapping
    a. Identify and connect with connect with local, state, and national resources (e.g., letters of support or memoranda of understanding)
    b. Conduct diversity or climate surveys
    c. Identify "safe space resource champions" who can provide resources and share information
3. Develop train-the-trainer resources for staff to provide local learning events
4. Connect with other national system of care sites to identify inclusive treatment models
5. Conduct social marketing activities to change voluntary behavior toward acceptance and inclusion

To find out more information about XPand, please visit:

www.dmh.ms.gov
www.weemsmh.com
www.turnaround-achievement.net

THE MISSISSIPPI DEPARTMENT OF MENTAL HEALTH

SUPPORTING A BETTER TOMORROW...TODAY