

# Mississippi

## UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND  
PLAN

## SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020  
(generated on 05/07/2018 3.11.37 PM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

## State Information

### State Information

#### Plan Year

Start Year 2017

End Year 2018

#### State DUNS Number

Number 809399926

Expiration Date

#### I. State Agency to be the Grantee for the Block Grant

Agency Name Mississippi Department of Mental Health

Organizational Unit Bureau of Alcohol and Drug Services

Mailing Address 239 North Lamar St., 1101 Robert E. Lee Bldg., Suite 801

City Jackson

Zip Code 39201

#### II. Contact Person for the Grantee of the Block Grant

First Name Melody

Last Name Winston

Agency Name MS Department of Mental Health

Mailing Address 239 North Lamar St

City Jackson

Zip Code 39201

Telephone 6013595198

Fax 6013596672

Email Address melody.winston@dmh.ms.gov

#### III. Expenditure Period

##### State Expenditure Period

From

To

#### IV. Date Submitted

Submission Date 9/29/2017 12:54:09 PM

Revision Date 5/7/2018 3:10:26 PM

#### V. Contact Person Responsible for Application Submission

First Name Jan

Last Name Dawson

Telephone 601-359-5142

Fax 601-359-6672

Email Address jan.dawson@dmh.ms.gov

#### Footnotes:



# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
Section 1922	Certain Allocations	<a href="#">42 USC § 300x-22</a>
Section 1923	Intravenous Substance Abuse	<a href="#">42 USC § 300x-23</a>
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	<a href="#">42 USC § 300x-24</a>
Section 1925	Group Homes for Recovering Substance Abusers	<a href="#">42 USC § 300x-25</a>
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	<a href="#">42 USC § 300x-26</a>
Section 1927	Treatment Services for Pregnant Women	<a href="#">42 USC § 300x-27</a>
Section 1928	Additional Agreements	<a href="#">42 USC § 300x-28</a>
Section 1929	Submission to Secretary of Statewide Assessment of Needs	<a href="#">42 USC § 300x-29</a>
Section 1930	Maintenance of Effort Regarding State Expenditures	<a href="#">42 USC § 300x-30</a>
Section 1931	Restrictions on Expenditure of Grant	<a href="#">42 USC § 300x-31</a>
Section 1932	Application for Grant; Approval of State Plan	<a href="#">42 USC § 300x-32</a>
Section 1935	Core Data Set	<a href="#">42 USC § 300x-35</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>

Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

# LIST of CERTIFICATIONS

## 1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

## 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

## 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Diana Mikula

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Executive Director

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

### Note:

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal

Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## **LIST of CERTIFICATIONS**

### **1. CERTIFICATION REGARDING LOBBYING**

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

### **2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

### **3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee<sup>1</sup>:



Title:

Executive Director

Date Signed:

08-29-17

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

# State Information

## Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

---

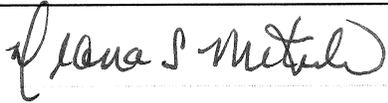
Name

Title

Organization

---

Signature:



Date:

8/28/17

**Footnotes:**



PHIL BRYANT  
GOVERNOR

September 1, 2015

Virginia Simmons  
Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Rd, Room 7-1109  
Rockville, MD 20857

Dear Ms. Simmons:

I designate the Mississippi Department of Mental Health as the state agency to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG) in Mississippi. I designate the Executive Director of the Mississippi Department of Mental Health, Diana Mikula, to apply for the block grant and to sign all assurances and submit all information required by federal law and the application guidelines. These designations are for the duration of my current term of office.

If you have any questions, please contact Ms. Mikula or Jake Hutchins, Director of the Bureau of Community Services, at (601) 359-1288 or by email at [jake.hutchins@dmh.state.ms.us](mailto:jake.hutchins@dmh.state.ms.us).

Sincerely,

A handwritten signature in blue ink that reads "Phil Bryant".

Phil Bryant  
GOVERNOR

## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

---

Name

Diana Mikula

Title

Executive Director

Organization

Mississippi Department of Mental Health

---

Signature:

Date:

**Footnotes:**

## Planning Steps

### Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

---

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

**Footnotes:**

## Needs Assessment

The State Public Mental Health Service System is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

The Service Delivery System is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

The Board of Mental Health governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

The Department of Mental Health Central Office is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of bureaus.

The Bureau of Administration works in concert with all bureaus to administer and support development and administration of mental health services in the state. Information Systems is also a part of the bureau.

The Bureau of Community Mental Health Services is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services for adults with serious mental illness and children with serious emotional disturbance. This includes crisis response as well as access to care and training to assist with the care and treatment of persons with Alzheimer's disease/other dementia.

The Bureau of Alcohol and Drug Services has the responsibility of administering fiscal resources (state and federal) to the public system of prevention, treatment, and recovery supports for persons with substance use disorders. The overall goal of the state's substance use disorder service system is to provide quality care within a

continuum of accessible community-based services including: prevention, outpatient, withdrawal management, intensive outpatient, primary and transitional residential treatment, opioid treatment services and recovery support.

The Bureau of Mental Health is responsible for the planning, development and supervision of an array of services for individuals served at the state-operated behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development and supervision of an array of services for people in the state with intellectual and developmental disabilities. The service delivery system is comprised of the ID/DD Waiver program, the IDD Community Support Program, and five state-operated comprehensive IDD programs located in communities throughout the state. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by community mental health centers and other community service providers.

The Bureau of Outreach, Planning and Development is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also

oversees internal and external communications, public awareness campaigns, suicide prevention efforts, government affairs, and developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH.

The Bureau of Human Resources is responsible for the employment and personnel matters of each of the Bureaus. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau is responsible for workforce development which is inclusive of managing the on-line learning system, organizing training opportunities for employees and assisting with the documentation of employee training credits. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

## Functions of the Mississippi Department of Mental Health

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with

those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

**State Certification and Program Monitoring:** Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

**State Role in Funding Community-Based Services:** The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

**Services/Supports Overview:** The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use 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, the State Legislature, the 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: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**State-Operated Programs:** DMH administers and operates state behavioral health programs, a mental health community living program, a specialized behavioral health program for youth, regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use disorders. These programs include:

Mississippi State Hospital and its satellite program Specialized Treatment Facility;  
East Mississippi State

Hospital and its satellite programs - North Mississippi State Hospital, South Mississippi State Hospital and Central Mississippi Residential Center. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, East Mississippi State Hospital provides transitional, community-based care. The programs for persons with intellectual and developmental disabilities provide residential services. The programs also provide licensed homes for community living. These programs include: Boswell Regional Center and its satellite program Mississippi Adolescent Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

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 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs.

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 and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

## COMPONENTS OF THE SUBSTANCE USE DISORDERS PREVENTION AND TREATMENT SERVICE SYSTEM

*The components of the substance use disorders prevention and treatment service system are aligned with the Department of Mental Health's Strategic Plan. The components encompass the strategic plan's nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training, and information management.*

### PREVENTION SERVICES

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco and other drug addictions. Based on identified risk and protective factors, these activities must be carried out in an intentional, comprehensive, and systematic way to impact large numbers of people.

Most substance use disorder prevention programs today are targeted at youth; however, the prevalence of substance use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use disorders determine, to a large extent, the environment in which choices will be made about use by children and adolescents. Therefore, the Bureau of Alcohol and Drug Services supports prevention services that target adults as well as young people.

The causes of substance use disorders are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and media messages often promote or convey acceptance of drug use behaviors. All of these factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in a variety of different ways. The Bureau of Alcohol and Drug Services requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental. (The definition of each strategy may be found at <http://dbhdid.ky.gov/pds/ServiceTypeCodes.pdf>).

Through the Bureau of Alcohol and Drug Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Alcohol and Drug Services has instituted many new policies for sub-

grantees funded by the 20 percent prevention set aside of the SABG. Two examples include: 1) designation of an individual to coordinate prevention services, and 2) requiring each program to implement at least one evidence-based program. The State Incentive Grant (SIG), awarded to the Bureau of Alcohol and Drug Services in 2001, allowed the Bureau of Alcohol and Drug Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Alcohol and Drug Services received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals:

(1) Build prevention capacity and infrastructure at state and community levels; (2) prevent the onset and reduce the progression of substance use, including childhood and underage drinking; and (3) Reduce substance use-related problems in communities. In 2012 the Bureau of Alcohol and Drug Services was awarded the Partnership for Success II Grant from SAMHSA/CSAP which will continue to combat underage drinking and related consequences but also target the reduction of prescription drug abuse rates and consequences for youth and young adults.

## **TREATMENT SERVICES**

### Treatment Modalities

The Bureau of Alcohol and Drug Services encourages “Best Practices” that aim to investigate the potential problem of substance use disorders and motivate the individual to do something about it either by natural, client-directed means or by seeking additional treatment. This can be done by utilizing brief interventions in an outpatient setting, which is the most common modality of treatment. If the individual needs a more intense level of treatment, a residential setting is recommended. Some evidence-based practices currently being utilized in treatment are brief interventions, group-based approaches to therapy, Cognitive-Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, Applied Suicide Intervention Skills Training, Trauma Focused-Cognitive Behavioral Therapy, and 12 Step Facilitation.

### Family Support

For many individuals with substance use disorders, interaction with their family is vital to the recovery process. The family has a central role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the user relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access, and knowledge of the referral and placement process.

### **Access to Community-Based Primary Residential Services**

The Primary Residential Treatment Program is a twenty-four hour, seven days a week on-site residential program for adult males and females who have substance use

disorders. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive. Primary residential treatment programs operate on a 30-day cycle, on average.

Primary residential treatment's group living environment offers clients access to a comprehensive program of services that is easily accessible and immediately responsive to each client's individual needs. Because substance dependency is a multidimensional problem, various treatment modalities are available; including withdrawal management; group and individual therapy; family therapy; education/information services explaining alcohol/drug use and dependency; personal growth/self-help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process and is designed to meet the specific needs of each client.

Although all substance use disorders treatment programs are accessible to pregnant women, there are two specifically designed for this population. Additionally, there are primary residential treatment programs tailored for adolescents and for persons in the criminal justice system. The Bureau of Alcohol and Drug Services supports specialized services for the following populations:

Specialized Primary Residential Services for Pregnant Women and Women with Dependent Children: In addition to traditional treatment modalities described above, these programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

Specialized Primary Residential Services for Adolescents: While providing many of the same therapeutic, informational/educational, and social/recreational services as adult programs, the content is modified to accommodate the substance using adolescent population. Adolescent treatment programs are generally longer in duration than adult primary residential programs. Some allow the client to remain from six months to a year, depending on several factors that may include the program's recommendations, parental participation, and the client's progress and adaptability. Also, all programs provide regularly scheduled academic classes individually designed for each client following a MS Department of Education approved curriculum by an MDE certified teacher.

Specialized Services for Persons in the Criminal Justice System: Substance use disorders screening and a primary treatment unit are provided for the inmates at the Mississippi Correctional Facility in Parchman.

### **Access to Community-Based Transitional Residential Services**

The Transitional Residential Treatment Program is a less intensive program for adult males and females, who typically remain from two to six months depending on the

individual needs of the client. The client must have completed a primary treatment program before being eligible for participation in a transitional program.

Intended to be an intermediate stage between primary treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive and fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid in the pursuit and acquisition of vocational, employment, and/or related activities. Although all substance use disorder treatment programs are accessible to pregnant women, there are two specifically designed for this population. There are also programs that provide services for female ex-offenders and adult males who have been diagnosed with co-occurring disorders.

Specialized Transitional Residential Services for Pregnant Women and Women with Dependent Children: These programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. In addition to traditional therapeutic activities, the treatment program also focuses on parenting skills education, nutrition, medical, and other needed services.

Specialized Transitional Residential Services for Female Ex-offenders: This program provides immediate support for women leaving primary treatment programs in correctional facilities.

### **Access to Community-Based Outpatient Services**

Each program providing substance use disorder outpatient services must provide multiple treatment modalities, techniques, and strategies which include individual, group, and family counseling. Program staff must include professionals representing multiple disciplines who have clinical training and experience specifically pertaining to the provision of substance use disorders.

General Outpatient: This program is appropriate for individuals whose clinical condition or environmental circumstances do not require an intensive level of care. The duration of treatment is tailored to individual needs and may vary from a few months to several years.

General Outpatient Services for Opiate Addiction: The Bureau of Alcohol and Drug Services in collaboration with the Center for Substance Abuse Treatment (CSAT) continues its relationship in addressing issues of treatment for individuals who are addicted to prescription pain medications and patients who are addicted to heroin and other opiates. The State Methadone Authority (SMA) works closely with the State's opiate replacement program to support programs which stress the core values of opiate treatment including the right of the individual to be treated with dignity and respect.

Intensive Outpatient Program (IOP) for Adults: This program provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance

use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week.

Specialized Intensive Outpatient Services for Adolescents: These programs operate in the same manner as those described above, but focus on the special needs of adolescents. The program allows the young person to maintain responsibilities related to education, family, employment and community while receiving treatment.

### **Access to Hospital-Based Inpatient Chemical Dependency Unit Services**

Inpatient or hospital-based programs offer treatment and rehabilitation services for individuals whose substance use problems require a medically monitored environment. These may include: (a) patients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting; (b) patients in withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes withdrawal management, assessment and evaluation, intervention counseling, aftercare, a family support program, and referral services.

Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance use. The program is designed to break the cycle of being frequently hospitalized by treating the substance use simultaneously with the mental illness.

## **SUPPORT SERVICES**

### **Access to Recovery Support Services**

A key component to a Person-Centered Recovery Oriented System of Care is recovery support services. These services are non-clinical services that assist individuals and their families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. Recovery support services may be provided in conjunction with treatment and/or as separate and distinct services to individuals and families who desire and need them. Recovery support services may be delivered by peers, professionals, faith-based and community-based groups, and others designed to help individuals stabilize and sustain their recovery. They also may provide structured support and assistance to the client in making referrals to secure additional needed services from community mental health

centers or from other health or human services providers while maintaining contact and involvement with the client's family. Research indicates that strong social supports assist recovery and recovery outcomes.

### **Access to Services for the Older Adult**

Services are provided to the older adult with substance use disorder issues and/or their families by providing information and access to needed treatment. Alcohol and prescription drug misuse and abuse are prevalent among older adult's due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. Substance dependence are directly correlated with other potential causes of cognitive impairment. Coupled with drug addiction and cognitive impairment, they should be encouraged to seek appropriate treatment. Counselors often use the opportunity to educate the older adult and to help them to acknowledge their addiction. Patient understanding and cooperation for the older adult are essential in eliciting accurate information in order to carry out the appropriate type of treatment. Depending on the individual's situation, the person's needs may change over time and require various levels and intensities of rehabilitation.

### **DUI Diagnostic Assessment Services**

Diagnostic Assessment Services are for individuals who have been convicted of two or more DUI violations which have resulted in the suspension of their driver's license. The DUI (Driving Under the Influence) Diagnostic Assessment is a process by which the diagnostic assessment, Substance Abuse Subtle Screening Inventory (SASSI) is administered and the result is combined with other required information to determine the offender's appropriate treatment environment for second and subsequent offenders.

The diagnostic assessment process ensures the following steps are taken. First, an approved DMH diagnostic assessment instrument is administered. Second, the results of the initial assessment along with the DMH Substance Abuse Specific Assessment are evaluated. Third, the Blood Alcohol Content (BAC) and the motor vehicle report are reviewed. And last, collateral contacts along with other clinical observations, if appropriate, are recorded. After this process is completed, the DUI offender is placed or referred to the appropriate treatment environment for services.

The Mississippi Implied Consent Law was amended during the last legislative session of 2014 and House Bill 412 was passed. The effective date of this bill was moved from July 1, 2014 to October 1, 2014 because of all the changes that were needed to insure compliancy without current state and federal laws/guidelines. One major change was that this law made it possible for all convicted DUI offenders, first through third, to secure an ignition interlock and a new special driver's license. Because of these two provisions, ignition interlock and a special license, a convicted offender could still drive while they are under suspension. Several service providers have voiced their concerns that these changes will cause a decrease in offender seeking services. The Bureau of Alcohol and Drug Services will monitor the numbers of offender seeking services by reviewing the Certification of DUI In-Depth Diagnostic Assessment and

Treatment Program Completion Forms, DUI Data System, and the Central Data Repository (CDR).

### **Tuberculosis and HIV/AIDS Assessment/Educational Services**

All individuals receiving substance use disorder treatment services are assessed for the risk of tuberculosis and HIV/AIDS. If the results of the assessment indicate the individual to be at high risk for infection, testing is made available. Individuals also receive educational information regarding HIV/AIDS, STDs, TB, and Hepatitis either in individual or group sessions during the course of treatment.

### **Referral Services**

For many years the Bureau of Alcohol and Drug Services has published the Mississippi Alcohol and Drug Prevention and Treatment Resources Directory in order for the public to access substance use disorder services. The directory is comprised of all DMH certified substance use treatment and prevention programs as well as other recognized programs across the state of Mississippi. It is revised, updated and redistributed by the Bureau of Alcohol and Drug Services every three years. The 2015-2017 publication will be distributed in December of 2015 to treatment facilities, human services organizations, and a wide variety of other interested parties statewide. The manual is extensively used for a variety of referral purposes. Approximately 5,000 copies have been distributed throughout the United States over the past few years. In addition, individuals seeking referral information through the Department of Mental Health may do so by contacting a toll-free help line, operated by the DMH Office of Consumer Support

## **OVERVIEW OF THE STATE ORGANIZATION**

**The State Public Mental Health Service System** is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

**The Service Delivery System** is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**The Board of Mental Health** governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

**The Department of Mental Health Central Office** is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of seven (7) bureaus.

**The Bureau of Administration** works in concert with all bureaus to administer and support development and administration of mental health services in the state. **Information Systems is also a part of the Bureau.**

**The Bureau of Community Mental Health Services** is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services for adults with serious mental illness and children with serious emotional disturbance. This includes crisis response as well as access to care and training to assist with the care and treatment of persons with Alzheimer's disease/other dementia.

**The Bureau of Alcohol and Drug Services** has the responsibility of administering fiscal resources (state and federal) to the public system of prevention, treatment, and recovery supports for persons with substance use disorders. The overall goal of the state's substance use disorder service system is to provide quality care within a continuum of accessible community-based services including: prevention, outpatient, withdrawal management, intensive outpatient, primary and transitional residential treatment, opioid treatment services and recovery support.

**The Bureau of Mental Health** is responsible for the planning, development and supervision of an array of services for individuals served at the state-operated behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes.

**The Bureau of Intellectual and Developmental Disabilities** is responsible for planning, development and supervision of an array of services for people in the state with intellectual and developmental disabilities. The service delivery system is comprised of the ID/DD Waiver program, the IDD Community Support Program, and five state-operated comprehensive IDD programs located in communities throughout the state. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by community mental health centers and other community service providers.

**The Bureau of Outreach, Planning and Development** is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also oversees internal and external communications, public awareness campaigns, suicide prevention efforts, government affairs, and developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH.

**The Bureau of Human Resources** is responsible for the employment and personnel matters of each of the Bureaus. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau is responsible for workforce development which is inclusive of managing

the on-line learning system, organizing training opportunities for employees and assisting with the documentation of employee training credits. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

### **Inter-Bureau Collaboration**

The Bureau of Alcohol and Drug Services collaborates with all six (6) other bureaus in the Department of Mental Health. Inter-bureau collaboration is a vital component in carrying out the responsibilities and duties of the Department. The Bureau of Alcohol and Drug Services works closely with the following areas: Human Resources, Staff Development and Training, Certification and Licensure, Contracts Management, Grants Management, Purchasing, Recovery and Resiliency, Mental Health, and Referral and Placement.

## **FUNCTIONS OF THE MISSISSIPPI DEPARTMENT OF MENTAL HEALTH**

**State Level Administration of Community-Based Mental Health Services:** The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

**State Certification and Program Monitoring:** Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

**State Role in Funding Community-Based Services:** The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

## **OVERVIEW OF THE LOCAL LEVEL ORGANIZATION**

**Services/Supports Overview:** The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use 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, the State Legislature, the 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: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**State-Operated Programs:** DMH administers and operates state behavioral health programs, a mental health community living program, a specialized behavioral health program for youth, regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use disorders. These programs include: Mississippi State Hospital and its satellite program Specialized Treatment Facility; East Mississippi State

**State Hospital and Satellite Programs:** North Mississippi State Hospital, South Mississippi State Hospital and Central Mississippi Residential Center. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, East Mississippi State Hospital provides transitional, community-based care. The programs for persons with intellectual and developmental disabilities provide residential services. The programs also provide licensed homes for community living. These programs include: Boswell Regional Center and its satellite program Mississippi Adolescent Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

**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 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs.

**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 and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

**1. Give an overview of the state's behavioral health prevention, treatment, and recovery support systems, and describe how the public behavioral health system is currently organized at the state, intermediate and local levels.**

**COMPONENTS OF THE SUBSTANCE USE DISORDERS PREVENTION AND TREATMENT SERVICE SYSTEM**

*The components of the substance use disorders prevention and treatment service system are aligned with the Department of Mental Health's Strategic Plan. The components encompass the strategic plan's nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training, and information management.*

**PREVENTION SERVICES**

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco and other drug addictions. Based on identified risk and protective factors, these activities must be carried out in an intentional, comprehensive, and systematic way to impact large numbers of people.

Most substance use disorder prevention programs today are targeted at youth; however, the prevalence of substance use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use disorders determine, to a large extent, the environment in which choices will be made about use by children and adolescents. Therefore, the Bureau of Alcohol and Drug Services supports prevention services that target adults as well as young people.

The causes of substance use disorders are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and media messages often promote or convey acceptance of drug use behaviors. All of these factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in a variety of different ways. The Bureau of Alcohol and Drug Services requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental. (The definition of each strategy may be found at <http://dbhdid.ky.gov/pds/ServiceTypeCodes.pdf>).

Through the Bureau of Alcohol and Drug Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Alcohol and Drug Services has instituted many new policies for subgrantees funded by the 20 percent prevention set aside of the SABG. Two examples include: 1) designation of an individual to coordinate prevention services, and 2) requiring each program to implement at least one evidence-based program. The State Incentive Grant (SIG), awarded to the Bureau of Alcohol and Drug Services in 2001, allowed the Bureau of Alcohol and Drug Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Alcohol and Drug Services received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals:

(1) Build prevention capacity and infrastructure at state and community levels; (2) prevent the onset and reduce the progression of substance use, including childhood and underage drinking; and (3) Reduce substance use-related problems in communities. In 2012 the Bureau of Alcohol and Drug Services was awarded the Partnership for Success II Grant from SAMHSA/CSAP which will continue to combat underage drinking and related consequences but also target the reduction of prescription drug abuse rates and consequences for youth and young adults.

## **TREATMENT SERVICES**

### Treatment Modalities

The Bureau of Alcohol and Drug Services encourages “Best Practices” that aim to investigate the potential problem of substance use disorders and motivate the individual to do something about it either by natural, client-directed means or by seeking additional treatment. This can be done by utilizing brief interventions in an outpatient setting, which is the most common modality of treatment. If the individual needs a more intense level of treatment, a residential setting is recommended. Some evidence-based practices currently being utilized in treatment are brief interventions, group-based approaches to therapy, Cognitive-Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, Applied Suicide Intervention Skills Training, Trauma Focused-Cognitive Behavioral Therapy, and 12 Step Facilitation.

### Family Support

For many individuals with substance use disorders, interaction with their family is vital to the recovery process. The family has a central role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the user relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access, and knowledge of the referral and placement process.

## **Access to Community-Based Primary Residential Services**

The Primary Residential Treatment Program is a twenty-four hour, seven days a week on-site residential program for adult males and females who have substance use disorders. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive. Primary residential treatment programs operate on a 30-day cycle, on average.

Primary residential treatment's group living environment offers clients access to a comprehensive program of services that is easily accessible and immediately responsive to each client's individual needs. Because substance dependency is a multidimensional problem, various treatment modalities are available; including withdrawal management; group and individual therapy; family therapy; education/information services explaining alcohol/drug use and dependency; personal growth/self-help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process and is designed to meet the specific needs of each client.

Although all substance use disorders treatment programs are accessible to pregnant women, there are two specifically designed for this population. Additionally, there are primary residential treatment programs tailored for adolescents and for persons in the criminal justice system. The Bureau of Alcohol and Drug Services supports specialized services for the following populations:

Specialized Primary Residential Services for Pregnant Women and Women with Dependent Children: In addition to traditional treatment modalities described above, these programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

Specialized Primary Residential Services for Adolescents: While providing many of the same therapeutic, informational/educational, and social/recreational services as adult programs, the content is modified to accommodate the substance using adolescent population. Adolescent treatment programs are generally longer in duration than adult primary residential programs. Some allow the client to remain from six months to a year, depending on several factors that may include the program's recommendations, parental participation, and the client's progress and adaptability. Also, all programs provide regularly scheduled academic classes individually designed for each client following a MS Department of Education approved curriculum by an MDE certified teacher.

Specialized Services for Persons in the Criminal Justice System: Substance use disorders screening and a primary treatment unit are provided for the inmates at the Mississippi Correctional Facility in Parchman.

## **Access to Community-Based Transitional Residential Services**

The Transitional Residential Treatment Program is a less intensive program for adult males and females, who typically remain from two to six months depending on the individual needs of the client. The client must have completed a primary treatment program before being eligible for participation in a transitional program.

Intended to be an intermediate stage between primary treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive and fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid in the pursuit and acquisition of vocational, employment, and/or related activities. Although all substance use disorder treatment programs are accessible to pregnant women, there are two specifically designed for this population. There are also programs that provide services for female ex-offenders and adult males who have been diagnosed with co-occurring disorders.

Specialized Transitional Residential Services for Pregnant Women and Women with Dependent Children: These programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. In addition to traditional therapeutic activities, the treatment program also focuses on parenting skills education, nutrition, medical, and other needed services.

Specialized Transitional Residential Services for Female Ex-offenders: This program provides immediate support for women leaving primary treatment programs in correctional facilities.

## **Access to Community-Based Outpatient Services**

Each program providing substance use disorder outpatient services must provide multiple treatment modalities, techniques, and strategies which include individual, group, and family counseling. Program staff must include professionals representing multiple disciplines who have clinical training and experience specifically pertaining to the provision of substance use disorders.

General Outpatient: This program is appropriate for individuals whose clinical condition or environmental circumstances do not require an intensive level of care. The duration of treatment is tailored to individual needs and may vary from a few months to several years.

General Outpatient Services for Opiate Addiction: The Bureau of Alcohol and Drug Services in collaboration with the Center for Substance Abuse Treatment (CSAT) continues its relationship in addressing issues of treatment for individuals who are addicted to prescription pain medications and patients who are addicted to heroin and other opiates. The State Methadone Authority (SMA) works closely with the State's

opiate replacement program to support programs which stress the core values of opiate treatment including the right of the individual to be treated with dignity and respect.

Intensive Outpatient Program (IOP) for Adults: This program provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week.

Specialized Intensive Outpatient Services for Adolescents: These programs operate in the same manner as those described above, but focus on the special needs of adolescents. The program allows the young person to maintain responsibilities related to education, family, employment and community while receiving treatment.

### **Access to Hospital-Based Inpatient Chemical Dependency Unit Services**

Inpatient or hospital-based programs offer treatment and rehabilitation services for individuals whose substance use problems require a medically monitored environment. These may include: (a) patients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting; (b) patients in withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes withdrawal management, assessment and evaluation, intervention counseling, aftercare, a family support program, and referral services.

Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance use. The program is designed to break the cycle of being frequently hospitalized by treating the substance use simultaneously with the mental illness.

## **SUPPORT SERVICES**

### **Access to Recovery Support Services**

A key component to a Person-Centered Recovery Oriented System of Care is recovery support services. These services are non-clinical services that assist individuals and their families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. Recovery support services may be provided in conjunction with treatment and/or as

separate and distinct services to individuals and families who desire and need them. Recovery support services may be delivered by peers, professionals, faith-based and community-based groups, and others designed to help individuals stabilize and sustain their recovery. They also may provide structured support and assistance to the client in making referrals to secure additional needed services from community mental health centers or from other health or human services providers while maintaining contact and involvement with the client's family. Research indicates that strong social supports assist recovery and recovery outcomes.

### **Access to Services for the Older Adult**

Services are provided to the older adult with substance use disorder issues and/or their families by providing information and access to needed treatment. Alcohol and prescription drug misuse and abuse are prevalent among older adult's due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. Substance dependence are directly correlated with other potential causes of cognitive impairment. Coupled with drug addiction and cognitive impairment, they should be encouraged to seek appropriate treatment. Counselors often use the opportunity to educate the older adult and to help them to acknowledge their addiction. Patient understanding and cooperation for the older adult are essential in eliciting accurate information in order to carry out the appropriate type of treatment. Depending on the individual's situation, the person's needs may change over time and require various levels and intensities of rehabilitation.

### **DUI Diagnostic Assessment Services**

Diagnostic Assessment Services are for individuals who have been convicted of two or more DUI violations which have resulted in the suspension of their driver's license. The DUI (Driving Under the Influence) Diagnostic Assessment is a process by which the diagnostic assessment, Substance Abuse Subtle Screening Inventory (SASSI) is administered and the result is combined with other required information to determine the offender's appropriate treatment environment for second and subsequent offenders.

The diagnostic assessment process ensures the following steps are taken. First, an approved DMH diagnostic assessment instrument is administered. Second, the results of the initial assessment along with the DMH Substance Abuse Specific Assessment are evaluated. Third, the Blood Alcohol Content (BAC) and the motor vehicle report are reviewed. And last, collateral contacts along with other clinical observations, if appropriate, are recorded. After this process is completed, the DUI offender is placed or referred to the appropriate treatment environment for services.

The Mississippi Implied Consent Law was amended during the last legislative session of 2014 and House Bill 412 was passed. The effective date of this bill was moved from July 1, 2014 to October 1, 2014 because of all the changes that were needed to insure compliancy without current state and federal laws/guidelines. One major change was that this law made it possible for all convicted DUI offenders, first through third, to secure an ignition interlock and a new special driver's license. Because of these two provisions, ignition interlock and a special license, a convicted offender could still

drive while they are under suspension. Several service providers have voiced their concerns that these changes will cause a decrease in offender seeking services. The Bureau of Alcohol and Drug Services will monitor the numbers of offender seeking services by reviewing the Certification of DUI In-Depth Diagnostic Assessment and Treatment Program Completion Forms, DUI Data System, and the Central Data Repository (CDR).

### **Tuberculosis and HIV/AIDS Assessment/Educational Services**

All individuals receiving substance use disorder treatment services are assessed for the risk of tuberculosis and HIV/AIDS. If the results of the assessment indicate the individual to be at high risk for infection, testing is made available. Individuals also receive educational information regarding HIV/AIDS, STDs, TB, and Hepatitis either in individual or group sessions during the course of treatment.

### **Referral Services**

For many years the Bureau of Alcohol and Drug Services has published the Mississippi Alcohol and Drug Prevention and Treatment Resources Directory in order for the public to access substance use disorder services. The directory is comprised of all DMH certified substance use treatment and prevention programs as well as other recognized programs across the state of Mississippi. It is revised, updated and redistributed by the Bureau of Alcohol and Drug Services every three years. The 2015-2017 publication will be distributed in December of 2015 to treatment facilities, human services organizations, and a wide variety of other interested parties statewide. The manual is extensively used for a variety of referral purposes. Approximately 5,000 copies have been distributed throughout the United States over the past few years. In addition, individuals seeking referral information through the Department of Mental Health may do so by contacting a toll-free help line, operated by the DMH Office of Consumer Support

## **OVERVIEW OF THE STATE ORGANIZATION**

**The State Public Mental Health Service System** is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

**The Service Delivery System** is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**The Board of Mental Health** governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five

congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

**The Department of Mental Health Central Office** is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of seven (7) bureaus.

**The Bureau of Administration** works in concert with all bureaus to administer and support development and administration of mental health services in the state. **Information Systems is also a part of the Bureau.**

**The Bureau of Community Mental Health Services** is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services for adults with serious mental illness and children with serious emotional disturbance. This includes crisis response as well as access to care and training to assist with the care and treatment of persons with Alzheimer's disease/other dementia.

**The Bureau of Alcohol and Drug Services** has the responsibility of administering fiscal resources (state and federal) to the public system of prevention, treatment, and recovery supports for persons with substance use disorders. The overall goal of the state's substance use disorder service system is to provide quality care within a continuum of accessible community-based services including: prevention, outpatient, withdrawal management, intensive outpatient, primary and transitional residential treatment, opioid treatment services and recovery support.

**The Bureau of Mental Health** is responsible for the planning, development and supervision of an array of services for individuals served at the state-operated behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes.

**The Bureau of Intellectual and Developmental Disabilities** is responsible for planning, development and supervision of an array of services for people in the state with intellectual and developmental disabilities. The service delivery system is comprised of the ID/DD Waiver program, the IDD Community Support Program, and five state-operated comprehensive IDD programs located in communities throughout the state. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by community mental health centers and other community service providers.

**The Bureau of Outreach, Planning and Development** is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also oversees internal and external communications, public awareness campaigns, suicide prevention efforts, government affairs, and developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH.

**The Bureau of Human Resources** is responsible for the employment and personnel matters of each of the Bureaus. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau is responsible for workforce development which is inclusive of managing the on-line learning system, organizing training opportunities for employees and assisting with the documentation of employee training credits. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

### **Inter-Bureau Collaboration**

The Bureau of Alcohol and Drug Services collaborates with all six (6) other bureaus in the Department of Mental Health. Inter-bureau collaboration is a vital component in carrying out the responsibilities and duties of the Department. The Bureau of Alcohol and Drug Services works closely with the following areas: Human Resources, Staff Development and Training, Certification and Licensure, Contracts Management, Grants Management, Purchasing, Recovery and Resiliency, Mental Health, and Referral and Placement.

## **FUNCTIONS OF THE MISSISSIPPI DEPARTMENT OF MENTAL HEALTH**

**State Level Administration of Community-Based Mental Health Services:** The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

**State Certification and Program Monitoring:** Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

**State Role in Funding Community-Based Services:** The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

## **OVERVIEW OF THE LOCAL LEVEL ORGANIZATION**

**Services/Supports Overview:** The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use 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, the State Legislature, the 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: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**State-Operated Programs:** DMH administers and operates state behavioral health programs, a mental health community living program, a specialized behavioral health program for youth, regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use disorders. These programs include: Mississippi State Hospital and its satellite program Specialized Treatment Facility; East Mississippi State

**State Hospital and Satellite Programs:** North Mississippi State Hospital, South Mississippi State Hospital and Central Mississippi Residential Center. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, East Mississippi State Hospital provides transitional, community-based care. The programs for persons with intellectual and developmental disabilities provide residential services. The programs also provide licensed homes for community living. These programs include: Boswell Regional Center and its satellite program Mississippi Adolescent Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

**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 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs.

**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 and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

**1. Give an overview of the state's behavioral health prevention, treatment, and recovery support systems, and describe how the public behavioral health system is currently organized at the state, intermediate and local levels.**

**COMPONENTS OF THE SUBSTANCE USE DISORDERS PREVENTION SERVICE SYSTEM**

*The components of the substance use disorders prevention service system are aligned with the Department of Mental Health's Strategic Plan. The components encompass the strategic plan's nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training, and information management.*

**PREVENTION SERVICES**

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco and other drug addictions. Based on identified risk and protective factors, these activities must be carried out in an intentional, comprehensive, and systematic way to impact the vast majority of people.

Most substance use disorder prevention programs today are targeted at youth; however, the prevalence of substance use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use disorders determine, to a large extent, the environment in which choices will be made about substance use by children and adolescents. Therefore, the Bureau of Alcohol and Drug Services supports prevention services that target adults as well as young people.

The causes of substance use disorders are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and media messages often promote or convey acceptance of drug use behaviors. All of these factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research in order to be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in a variety of different ways. The Bureau of Alcohol and Drug Services requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental.

Through the Bureau of Alcohol and Drug Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Alcohol and Drug Services has policies for sub-grantees funded by the 20 percent prevention set aside of the SABG. Two examples include: 1) designation of an individual to coordinate prevention services, and 2) requiring each program to implement at least one evidence-based program. The State Incentive Grant (SIG), awarded to the Bureau of Alcohol and Drug Services in 2001, allowed the Bureau of Alcohol and Drug Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Alcohol and Drug Services received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals: (1) Build prevention capacity and infrastructure at state and community levels; (2) prevent the onset and reduce the progression of substance use, including childhood and underage drinking; and (3) Reduce substance use-related problems in communities. In 2012 the Bureau of Alcohol and Drug Services was awarded the Partnership for Success II Grant from SAMHSA, CSAP which continued to combat underage drinking and related consequences, but also target binge drinking among the young adult population and the related consequences, and target the reduction of prescription drug abuse rates and those related consequences for youth and young adults. In 2015, the Bureau of Alcohol and Drug Services received the SAMHSA, CSAP grant. The grant was entitled the Partnership for Success 2015 Grant. This grant continued the work of the PFS II grant; however, this grant concentrated heavily on serving high need communities and serving college communities. With resources from the PFS 2015 grant, we expanded our capacity by implementing the Mississippi Young Adult Survey in 2017. The purpose of the Mississippi Young Adult Survey was to collect substance use behavioral health indicators for the young adult population, ages eighteen through twenty-five, that could be used to establish baseline measurements and capture subsequent outcomes measurements at the community level. This was necessary to begin narrowing the gap of lacking community level consumption data among young adults in Mississippi. Even though the Mississippi Young Adult Survey is a huge step in the right direction for capturing consumption and consequence measures, BADS still lack measurements for those young adults that bypassed the collegiate path. This is an area that the state will work towards once the Mississippi Young Adult Survey has been fully implemented at all colleges throughout the state.

Mississippi has had many successes within the prevention field; however, there are still many challenges that exist. A major strength of Mississippi prevention system is that the state has over a decade of implementing a youth survey, which captured behavioral health indicators of over 100,000 adolescents for most of the years that the survey was administered. This achievement consisted of partnering with other state agencies to develop and finance the implementation of the youth survey beginning in 2001. The state began to lose momentum behind this survey after several major partners began to lose funding and could no longer help BADS finance the survey in 2014. The survey also took a major hit once the agency that originally owned the survey changed leadership and eventually folded. The SmartTrack survey was purchased by BADS in 2017 and is being managed internally. It hasn't gained its full momentum back;

however, we are hoping to strengthen our partnership with the Mississippi Department of Education in hopes that they will mandate that schools under their purview participate. The BADS will begin to rectify this by establishing a MOU with the Mississippi Department of Education. The BADS will also begin establishing relationships with private schools in Mississippi. In 2016, legislation was passed to allow charter schools in Mississippi. We will try to reach out to them as well.

Another challenge for the prevention services division within the BADS is that BADS has limited staff, which hinders the program ability to exercise quality control in all aspects of prevention programming and contracting. A major challenge related to community level prevention workforce is that the state experiences significant turnover among these providers, which places a significant burden on the state level staff. This also affects the continuity of services in those affected communities as new staff has to be trained before they can begin implementation. The Mississippi prevention workforce is currently struggling with understanding the importance of correctly implementing environmental strategies. Historically in Mississippi, state level staff directed the community level staff to primarily focus on individual level prevention strategies instead of population based prevention strategies. The state level staff will focus on making a paradigm shift to transition prevention programming to a primarily population based system that has a broader and long lasting positive impact on preventing negative substance use behaviors.

Mississippi lacks sufficient youth and young adult data on sexual minorities as it relates to their sexual orientation and gender identity, which makes it difficult to justify this population as a high priority in Mississippi or even target prevention efforts to them due to us not knowing what vicinity of the state they are in. Therefore, we believe that our array of prevention services for substance abuse is serving this community. Mississippi has made vigorous efforts to include sexual identity questions on the state's existing youth survey, SmartTrack. Mississippi will continue to petition for inclusion of these indicators, which are subject to approval from the Mississippi Department of Education. The creation of the Mississippi Young Adult Survey under the auspices of the Partnership for Success 2015 grant, presented us with our first opportunity to try and capture some data on this population. A question was included on our IRB approved young adult survey, which asks the participants to choose between three options as it relates to their sexual identity: Straight (heterosexuals), Bisexual, and Gay or Lesbian.

Cultural competence is a core value of Mississippi's alcohol and drug prevention system. The BADS addresses cultural competence through the inclusion and representation of individuals and agencies working with diverse ethnic and minority populations (including LGBTQs, American Indians, African Americans and Hispanic), youth, the military and veterans, and underserved populations on the Advisory Council, Mississippi Prevention Network, State Epidemiological Outcomes Workgroup and Evidence Based Workgroup. In addition, BADS has representation on the DMH Cultural Competency Taskforce. The BADS ensures that efforts are made in the collection and use of data from all at risk populations to identify disparities in substance abuse and mental health. The selection and use of culturally and linguistically appropriate programs that best fit the target population is a priority that is not only enforced but

also reinforced through staff and multiple prevention workforce trainings and through the provision of technical guidance and assistance. To further demonstrate the BADS' commitment to maintaining cultural competence, any additional project staff to be hired must illustrate experience in the areas mentioned above.

The SSA role in primary prevention is to provide oversight of the state Prevention Coordinator and all aspects of prevention services being provided in the state. The Prevention Coordinator directs all aspects of the prevention portion of the Substance Abuse Block Grant and oversees the prevention discretionary grants. The SSA has a statewide workforce training contract with the Mississippi Public Health Institute. The partnership between the Mississippi Department of Mental Health and the Mississippi Public Health Institute led to the development of the Mississippi Behavioral Health Learning Network (MSBHLN). More information about the services provided by the MSBHLN can be found using the following website: [www.msbhln.org](http://www.msbhln.org). The SSA funds a variety of industries for prevention services. The prevention services infrastructure consists of fourteen Community Mental Health Centers, one Tribal Behavioral Health Center, one Community Health Center, three Universities, and four free standing prevention programs. All of the funded prevention programs, regardless of industry, have active coalitions in their surrounding communities that help with the implementation of alcohol, tobacco, and other prevention strategies. There are three Regional Alcohol and Drug Awareness Resource (RADAR) Center's located throughout the state, covering the Northern, Central, and Southern regions of the state. The materials in the RADAR center are provided free of charge to Mississippi residents. The RADAR centers are statewide information clearinghouses with information on alcohol, tobacco, and other drugs as it relates to prevention, treatment, and recovery.

**1. Give an overview of the state's behavioral health prevention, treatment, and recovery support systems, and describe how the public behavioral health system is currently organized at the state, intermediate and local levels.**

**COMPONENTS OF THE SUBSTANCE USE DISORDERS PREVENTION AND TREATMENT SERVICE SYSTEM**

*The components of the substance use disorders prevention and treatment service system are aligned with the Department of Mental Health's Strategic Plan. The components encompass the strategic plan's nine (9) themes which include accountability, person-centeredness, access, community, outcomes, prevention awareness, partnerships, workforce training, and information management.*

**PREVENTION SERVICES**

Prevention is an awareness process that involves interacting with people, communities, and systems to promote the programs aimed at substantially preventing alcohol, tobacco and other drug addictions. Based on identified risk and protective factors, these activities must be carried out in an intentional, comprehensive, and systematic way to impact large numbers of people.

Most substance use disorder prevention programs today are targeted at youth; however, the prevalence of substance use indicates that all age groups are at risk. Since adults serve as role models, their behavior and attitudes toward substance use disorders determine, to a large extent, the environment in which choices will be made about use by children and adolescents. Therefore, the Bureau of Alcohol and Drug Services supports prevention services that target adults as well as young people.

The causes of substance use disorders are complex and multi-dimensional. According to research, factors that play a role in the development of drug dependency can include genetics or deficiencies in knowledge, skills, values, or spirituality. Also, social norms, public policies, and media messages often promote or convey acceptance of drug use behaviors. All of these factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in a variety of different ways. The Bureau of Alcohol and Drug Services requires that each funded program use no less than three of the six strategies promoted by the Substance Abuse Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Prevention (CSAP). The six strategies are information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental. (The definition of each strategy may be found at <http://dbhdid.ky.gov/pds/ServiceTypeCodes.pdf>).

Through the Bureau of Alcohol and Drug Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Alcohol and Drug Services has instituted many new policies for subgrantees funded by the 20 percent prevention set aside of the SABG. Two examples include: 1) designation of an individual to coordinate prevention services, and 2) requiring each program to implement at least one evidence-based program. The State Incentive Grant (SIG), awarded to the Bureau of Alcohol and Drug Services in 2001, allowed the Bureau of Alcohol and Drug Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Alcohol and Drug Services received a Substance Abuse and Mental Health Services Administration (SAMHSA) five-year incentive grant to meet the following federal goals:

(1) Build prevention capacity and infrastructure at state and community levels; (2) prevent the onset and reduce the progression of substance use, including childhood and underage drinking; and (3) Reduce substance use-related problems in communities. In 2012 the Bureau of Alcohol and Drug Services was awarded the Partnership for Success II Grant from SAMHSA/CSAP which will continue to combat underage drinking and related consequences but also target the reduction of prescription drug abuse rates and consequences for youth and young adults.

## **TREATMENT SERVICES**

### Treatment Modalities

The Bureau of Alcohol and Drug Services encourages “Best Practices” that aim to investigate the potential problem of substance use disorders and motivate the individual to do something about it either by natural, client-directed means or by seeking additional treatment. This can be done by utilizing brief interventions in an outpatient setting, which is the most common modality of treatment. If the individual needs a more intense level of treatment, a residential setting is recommended. Some evidence-based practices currently being utilized in treatment are brief interventions, group-based approaches to therapy, Cognitive-Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, Applied Suicide Intervention Skills Training, Trauma Focused-Cognitive Behavioral Therapy, and 12 Step Facilitation.

### Family Support

For many individuals with substance use disorders, interaction with their family is vital to the recovery process. The family has a central role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the user relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access, and knowledge of the referral and placement process.

## **Access to Community-Based Primary Residential Services**

The Primary Residential Treatment Program is a twenty-four hour, seven days a week on-site residential program for adult males and females who have substance use disorders. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive. Primary residential treatment programs operate on a 30-day cycle, on average.

Primary residential treatment's group living environment offers clients access to a comprehensive program of services that is easily accessible and immediately responsive to each client's individual needs. Because substance dependency is a multidimensional problem, various treatment modalities are available; including withdrawal management; group and individual therapy; family therapy; education/information services explaining alcohol/drug use and dependency; personal growth/self-help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process and is designed to meet the specific needs of each client.

Although all substance use disorders treatment programs are accessible to pregnant women, there are two specifically designed for this population. Additionally, there are primary residential treatment programs tailored for adolescents and for persons in the criminal justice system. The Bureau of Alcohol and Drug Services supports specialized services for the following populations:

Specialized Primary Residential Services for Pregnant Women and Women with Dependent Children: In addition to traditional treatment modalities described above, these programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.

Specialized Primary Residential Services for Adolescents: While providing many of the same therapeutic, informational/educational, and social/recreational services as adult programs, the content is modified to accommodate the substance using adolescent population. Adolescent treatment programs are generally longer in duration than adult primary residential programs. Some allow the client to remain from six months to a year, depending on several factors that may include the program's recommendations, parental participation, and the client's progress and adaptability. Also, all programs provide regularly scheduled academic classes individually designed for each client following a MS Department of Education approved curriculum by an MDE certified teacher.

Specialized Services for Persons who Inject Drugs: Above the traditional treatment modalities for this population, programs also focus on vocational, educational and medical needs of the individual.

Specialized Services for Persons in the Criminal Justice System: Substance use disorders screening and a primary treatment unit are provided for the inmates at the Mississippi Correctional Facility in Parchman.

### **Access to Community-Based Transitional Residential Services**

The Transitional Residential Treatment Program is a less intensive program for adult males and females, who typically remain from two to six months depending on the individual needs of the client. The client must have completed a primary treatment program before being eligible for participation in a transitional program.

Intended to be an intermediate stage between primary treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive and fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid in the pursuit and acquisition of vocational, employment, and/or related activities. Although all substance use disorder treatment programs are accessible to pregnant women, there are two specifically designed for this population. There are also programs that provide services for female ex-offenders and adult males who have been diagnosed with co-occurring disorders.

Specialized Transitional Residential Services for Pregnant Women and Women with Dependent Children: These programs provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. In addition to traditional therapeutic activities, the treatment program also focuses on parenting skills education, nutrition, medical, and other needed services.

Specialized Transitional Residential Services for Female Ex-offenders: This program provides immediate support for women leaving primary treatment programs in correctional facilities.

### **Access to Community-Based Outpatient Services**

Each program providing substance use disorder outpatient services must provide multiple treatment modalities, techniques, and strategies which include individual, group, and family counseling. Program staff must include professionals representing multiple disciplines who have clinical training and experience specifically pertaining to the provision of substance use disorders.

General Outpatient: This program is appropriate for individuals whose clinical condition or environmental circumstances do not require an intensive level of care. The duration of treatment is tailored to individual needs and may vary from a few months to several years.

General Outpatient Services for Opiate Addiction: The Bureau of Alcohol and Drug Services in collaboration with the Center for Substance Abuse Treatment (CSAT)

continues its relationship in addressing issues of treatment for individuals who are addicted to prescription pain medications and patients who are addicted to heroin and other opiates. The State Methadone Authority (SMA) works closely with the State's opiate replacement program to support programs which stress the core values of opiate treatment including the right of the individual to be treated with dignity and respect.

Intensive Outpatient Program (IOP) for Adults: This program provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week.

Specialized Intensive Outpatient Services for Adolescents: These programs operate in the same manner as those described above, but focus on the special needs of adolescents. The program allows the young person to maintain responsibilities related to education, family, employment and community while receiving treatment.

### **Access to Hospital-Based Inpatient Chemical Dependency Unit Services**

Inpatient or hospital-based programs offer treatment and rehabilitation services for individuals whose substance use problems require a medically monitored environment. These may include: (a) patients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting; (b) patients in withdrawal and who are at risk for a severe or complicated withdrawal syndrome; (c) those with an acute or chronic medical condition; (d) those who do not benefit from less intensive treatment; and/or (e) clients who may be a danger to themselves or others. In addition to medical services, treatment usually includes withdrawal management, assessment and evaluation, intervention counseling, aftercare, a family support program, and referral services.

Inpatient services also provide treatment for individuals with a co-occurring disorder of mental illness and substance use. The program is designed to break the cycle of being frequently hospitalized by treating the substance use simultaneously with the mental illness.

## **SUPPORT SERVICES**

### **Access to Recovery Support Services**

A key component to a Person-Centered Recovery Oriented System of Care is recovery support services. These services are non-clinical services that assist individuals and their families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services

that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. Recovery support services may be provided in conjunction with treatment and/or as separate and distinct services to individuals and families who desire and need them. Recovery support services may be delivered by peers, professionals, faith-based and community-based groups, and others designed to help individuals stabilize and sustain their recovery. They also may provide structured support and assistance to the client in making referrals to secure additional needed services from community mental health centers or from other health or human services providers while maintaining contact and involvement with the client's family. Research indicates that strong social supports assist recovery and recovery outcomes.

### **Access to Services for the Older Adult**

Services are provided to the older adult with substance use disorder issues and/or their families by providing information and access to needed treatment. Alcohol and prescription drug misuse and abuse are prevalent among older adult's due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. Substance dependence are directly correlated with other potential causes of cognitive impairment. Coupled with drug addiction and cognitive impairment, they should be encouraged to seek appropriate treatment. Counselors often use the opportunity to educate the older adult and to help them to acknowledge their addiction. Patient understanding and cooperation for the older adult are essential in eliciting accurate information in order to carry out the appropriate type of treatment. Depending on the individual's situation, the person's needs may change over time and require various levels and intensities of rehabilitation.

### **DUI Diagnostic Assessment Services**

Diagnostic Assessment Services are for individuals who have been convicted of two or more DUI violations which have resulted in the suspension of their driver's license. The DUI (Driving Under the Influence) Diagnostic Assessment is a process by which the diagnostic assessment, Substance Abuse Subtle Screening Inventory (SASSI) is administered and the result is combined with other required information to determine the offender's appropriate treatment environment for second and subsequent offenders.

The diagnostic assessment process ensures the following steps are taken. First, an approved DMH diagnostic assessment instrument is administered. Second, the results of the initial assessment along with the DMH Substance Abuse Specific Assessment are evaluated. Third, the Blood Alcohol Content (BAC) and the motor vehicle report are reviewed. And last, collateral contacts along with other clinical observations, if appropriate, are recorded. After this process is completed, the DUI offender is placed or referred to the appropriate treatment environment for services.

The Mississippi Implied Consent Law was amended during the last legislative session of 2014 and House Bill 412 was passed. The effective date of this bill was moved from July 1, 2014 to October 1, 2014 because of all the changes that were needed to insure compliancy without current state and federal laws/guidelines. One major change was

that this law made it possible for all convicted DUI offenders, first through third, to secure an ignition interlock and a new special driver's license. Because of these two provisions, ignition interlock and a special license, a convicted offender could still drive while they are under suspension. Several service providers have voiced their concerns that these changes will cause a decrease in offender seeking services. The Bureau of Alcohol and Drug Services will monitor the numbers of offender seeking services by reviewing the Certification of DUI In-Depth Diagnostic Assessment and Treatment Program Completion Forms, DUI Data System, and the Central Data Repository (CDR).

### **Tuberculosis and HIV/AIDS Assessment/Educational Services**

All individuals receiving substance use disorder treatment services are assessed for the risk of tuberculosis and HIV/AIDS. If the results of the assessment indicate the individual to be at high risk for infection, testing is made available. Individuals also receive educational information regarding HIV/AIDS, STDs, TB, and Hepatitis either in individual or group sessions during the course of treatment.

### **Referral Services**

For many years the Bureau of Alcohol and Drug Services has published the Mississippi Alcohol and Drug Prevention and Treatment Resources Directory in order for the public to access substance use disorder services. The directory is comprised of all DMH certified substance use treatment and prevention programs as well as other recognized programs across the state of Mississippi. It is revised, updated and redistributed by the Bureau of Alcohol and Drug Services every three years. The 2015-2017 publication will be distributed in December of 2015 to treatment facilities, human services organizations, and a wide variety of other interested parties statewide. The manual is extensively used for a variety of referral purposes. Approximately 5,000 copies have been distributed throughout the United States over the past few years. In addition, individuals seeking referral information through the Department of Mental Health may do so by contacting a toll-free help line, operated by the DMH Office of Consumer Support

## **OVERVIEW OF THE STATE ORGANIZATION**

**The State Public Mental Health Service System** is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

**The Service Delivery System** is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**The Board of Mental Health** governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is

composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

**The Department of Mental Health Central Office** is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of seven (7) bureaus.

**The Bureau of Administration** works in concert with all bureaus to administer and support development and administration of mental health services in the state. **Information Systems is also a part of the Bureau.**

**The Bureau of Community Mental Health Services** is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services for adults with serious mental illness and children with serious emotional disturbance. This includes crisis response as well as access to care and training to assist with the care and treatment of persons with Alzheimer's disease/other dementia.

**The Bureau of Alcohol and Drug Services** has the responsibility of administering fiscal resources (state and federal) to the public system of prevention, treatment, and recovery supports for persons with substance use disorders. The overall goal of the state's substance use disorder service system is to provide quality care within a continuum of accessible community-based services including: prevention, outpatient, withdrawal management, intensive outpatient, primary and transitional residential treatment, opioid treatment services and recovery support.

**The Bureau of Mental Health** is responsible for the planning, development and supervision of an array of services for individuals served at the state-operated behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes.

**The Bureau of Intellectual and Developmental Disabilities** is responsible for planning, development and supervision of an array of services for people in the state with intellectual and developmental disabilities. The service delivery system is comprised of the ID/DD Waiver program, the IDD Community Support Program, and five state-operated comprehensive IDD programs located in communities throughout the state. The ID/DD Waiver and Community Support Programs provide support to assist people to live successfully at home and in the community. These services are provided by community mental health centers and other community service providers.

**The Bureau of Outreach, Planning and Development** is responsible for the agency's strategic planning process including the DMH Strategic Plan and the Legislative Budget Office Five Year Plan. The Bureau also oversees internal and external communications, public awareness campaigns, suicide prevention efforts, government affairs, and developing and implementing licensure and certification programs for categories of professionals who are employed at programs which are operated, funded and/or certified by DMH.

**The Bureau of Human Resources** is responsible for the employment and personnel matters of each of the Bureaus. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau is responsible for workforce development which is inclusive of managing the on-line learning system, organizing training opportunities for employees and assisting with the documentation of employee training credits. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

### **Inter-Bureau Collaboration**

The Bureau of Alcohol and Drug Services collaborates with all six (6) other bureaus in the Department of Mental Health. Inter-bureau collaboration is a vital component in carrying out the responsibilities and duties of the Department. The Bureau of Alcohol and Drug Services works closely with the following areas: Human Resources, Staff Development and Training, Certification and Licensure, Contracts Management, Grants Management, Purchasing, Recovery and Resiliency, Mental Health, and Referral and Placement.

## **FUNCTIONS OF THE MISSISSIPPI DEPARTMENT OF MENTAL HEALTH**

**State Level Administration of Community-Based Mental Health Services:** The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

**State Certification and Program Monitoring:** Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

**State Role in Funding Community-Based Services:** The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

## **OVERVIEW OF THE LOCAL LEVEL ORGANIZATION**

**Services/Supports Overview:** The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance use 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, the State Legislature, the 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: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

**State-Operated Programs:** DMH administers and operates state behavioral health programs, a mental health community living program, a specialized behavioral health program for youth, regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance use disorders. These programs include: Mississippi State Hospital and its satellite program Specialized Treatment Facility; East Mississippi State

**State Hospital and Satellite Programs:** North Mississippi State Hospital, South Mississippi State Hospital and Central Mississippi Residential Center. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, East Mississippi State Hospital provides transitional, community-based care. The programs for persons with intellectual and developmental disabilities provide residential services. The programs also provide licensed homes for community living. These programs include: Boswell Regional Center and its satellite program Mississippi Adolescent Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center.

**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 14 CMHCs make available a range of community-based mental health, substance use, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs.

**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 and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

## Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system.

---

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's population- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>1</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

---

<sup>1</sup> <http://www.healthypeople.gov/2020/default.aspx>

**Footnotes:**

## Gaps

Mississippi's current system gaps are addressed on an ongoing basis in that resources are allocated in an equitable manner to throughout the 14 Community Mental Health Centers (CMHC). It is through this infrastructure that all eighty-two counties in the state are served. Each CMHC provides the core services outlined by SAMHSA/CSAP by having a centralized hub for each region with satellite centers located throughout the catchment area to assist in service delivery.

This system of service delivery is supplemented by Free Standing Service Providers. This version of community level service providers allow much needed services to be available throughout the state in a very geographical diverse manner, without having to be a CMHC. Additionally, these community level service providers have been are funded in efforts to help reduce the gap in between service areas. Two State Universities have been funded and entered into a MOU for prevention service delivery in the past year. The addition of these to community level service provider is being considered an investment of Mississippi's SABG Resources that will render the most bang for the buck. This is considered to be a wise investment of resources because the decision was data driven and multiple targeted populations can easily be reached through universities.

## **Trauma Workforce**

Mississippi's Single State Agency, The Department of Mental Health (DMH) is committed to continuously training its Staff and Staff of its sub grantees in effort to provide a more trauma informed system of care/service provision. DMH provides an annual training to all service providers with several smaller versions throughout the calendar year. Trauma informed care and service provision education and trainings are also offered 4-6 times per year through a workforce development contract. DMH acknowledges a need to continue to develop the skills and knowledge base of its workforce in all areas of service delivery in respect to the role that trauma plays in today's social service delivery system(s).

# Service System Needs

## Needs:

- The need to address adults with co-occurring disorders (mental illness and substance use disorders) in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross system collaboration and education.
- To decrease turnover and increase the overall skill level of the professionals within the community mental health centers and other alcohol and drug service providers certified by DMH. Availability of additional workforce, particularly psychiatric/medical staff and Licensed Professional Counselors, is an ongoing challenge in providing and improving services.
- Development of a comprehensive plan to expand primary and transitional residential services for pregnant and parenting women and adolescents in the southern area of the state.
- Continue focus on improving transition of substance using individuals from state hospitals/facilities back to their home communities and enhance existing intensive supports for follow-up services and recovery support.
- The need for additional vocational skills training to those individuals completing primary treatment by increasing funding for transitional services.
- To increase prevention trainings to youth who may be at risk.
- Work to improve the Mississippi Management Information System in order to increase the quality of existing data, to expand capability to retrieve data on a timely basis and expand the types of data collected to increase information on outcomes as needed.
- Information Technology Gaps continue to exist within the State's prevention and treatment infrastructure. Funding remains a barrier but an unwillingness to support innovation and advancement in technology on behalf of the SSA's administration impedes progress in these areas. Social media, onsite Wi-Fi and limited internet capacity limits the potential for growth within the infrastructure. Several other aspects of the data collection and management are in vast need of improvement but may also benefit from a paradigm shift.

- Continue to collaborate with the Division of Medicaid to further define and develop Intensive Outpatient Services and expand the CMHCs capacity to provide these intensive services to adults and adolescents with co-occurring disorders (mental illness and substance use disorders).
- The entire state is much underserved for any level of MAT. The central part of the state is the location of the only Methadone treatment clinic in the state. The Methadone clinic is a cash only clinic and does not bill third party insurance or Medicaid. There are few scattered Doctors across the state that currently prescribes Suboxone, but the clinics are often full and services are only rendered for cash clients. The State is working on several initiatives in order to provide technical assistance to certified and funded programs in order to increase the use of MAT and change the community perception of the treatment.
- The CMHCs are having significant difficulty moving to a paperless environment. Electronic Health Records (EHR) is very costly and the smaller agencies cannot afford the installation, operational, and maintenance expenses. Causing significant difficulty to bill Medicaid and 3<sup>rd</sup> party insurances. In addition, there is no uniformity in the systems. There are no assurances that the EHR systems will transfer or properly communicate with other systems.

### 3. Address how these systems address the needs of diverse, racial, ethnic and gender minorities as well as youth who are often underserved.

The state of Mississippi (MS) has a very diverse population compared to other states. The majority of the population or 59.8% consists of Caucasians. African Americans account for 37.4% of the population, which is the highest percentage of African Americans among the fifty states in the US, according to the US Census. American Indians and Alaska Natives account for .6%; Asians account for 1%; Native Hawaiians and Other Pacific Islander account for .1%; Historically, Mississippi has been a socio-economically challenged state because of the high levels of poverty combined with lower educational attainment for those economically challenged. The MS Department of Mental Health defines Cultural Competency as the acceptance and respect for difference, continuing self-assessment regarding culture, attention to dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations.

Activities implemented under the auspices of the public behavioral health system are developed and conducted in a manner that respects the cultural distinctiveness and diversity of those served by the local community mental health centers and prevention agencies throughout the state of Mississippi (MS). The MS Department of Mental Health's Bureau of Alcohol and Drug Services staff itself is culturally diverse and has extensive experience implementing programs to socially disadvantaged populations in a culturally competent fashion. All certified and funded providers are required to place an emphasis on language and literacy, and accommodate all individuals regardless of race, ethnicity, sexual orientation, gender identity and disability. In the MS Department of Mental Health's Operational Standards it states that "Providers must put in place quality management strategies that at a minimum: collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services"; "At a minimum, general orientation must address the following area: Family/Cultural Issues and Respecting Cultural Differences"; "There must be written and implemented policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal representative(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. These rights are applicable to all individuals receiving services except for individuals that have been civilly committed or individuals who are confined to a correctional facility. The individual receiving services and/or parent/legal representative must also be given a written copy of these rights, which at a minimum, must include: The services within the program and other services available regardless of cultural barriers and limited English proficiency"; 4. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services. A detailed description of when and how these services will be provided must be clearly explained in the provider's policies and procedures. B. All providers must develop and implement policies and procedures that address

Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Human Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. All policies and procedures must include the following. 1. The process for offering 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 services. 2. How the agency informs individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. 3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. 4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the population in the service area. C. Cultural competence describes the ability of an agency to provide services to individuals with diverse values, beliefs, and behaviors, including tailoring service delivery to meet the individual's social, cultural and linguistic needs. Policies and procedure manual must

reflect the agency's efforts to integrate values, attitudes and beliefs of the individuals served into the services provided"; "Services and programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized for each individual receiving service"; "Services and plan development must reflect cultural considerations of the individual and be conducted by providing information in a plain language and in a manner that is accessible to the individuals and persons who have limited English proficiency";

MS has identified two special populations as defined by geographical regions: (1) the MS Gulf Coast and (2) the Mississippi Delta. Populations in these geographical regions have demonstrated persistent and elevated vulnerability to the substance use risks and contributing factors prioritized by the Substance Abuse Block Grant.

Substance use and mental health problems exhibited along the Gulf Coast have been compounded by Hurricane Katrina and the Deepwater Horizon oil spill. These disasters represented a loss of social and economic support for many community residents, leading to an increase in adverse mental health conditions. The behavioral health status of residents plummeted following Hurricane Katrina, and is strongly suspected to have contributed to increasing problems with substance abuse and dependence, psychiatric disorders, and familial breakdown, including divorce and domestic violence. The social impact and aftermath of Hurricane Katrina has been identified as one of the most severe humanitarian crises in U.S. history. Youth were not immune from the widespread symptoms of depression and posttraumatic stress brought about by Hurricane Katrina. For many youth, separation from a caregiver was coupled with temporary housing only to be followed by relocation to trailers. Many residents lost loved ones as their possessions were gone and their communities were leveled.

Youth are among those most severely affected by mental distress after a disaster and often exhibit long-lasting adverse effects such as future domestic abuse, suicidal ideation, criminal behavior, and drug dependence/abuse. A comprehensive report, *The Children's First Annual* (2012), indicates that the Gulf Coast region is in desperate need of assistance to combat unusually elevated school dropout rates, large percentages of children living in poverty, and lackluster educational aspirations among youth. These problems have been especially pervasive in Hancock County, where school assessments and screeners show a marked increase in drug use, drug dependence, depression, anxiety, and suicidal ideation. As such, it is crucial to continue to provide support and services to address the needs of this community.

Second, the MS Delta region, is marked by several racial, cultural, and economic disadvantages. The Delta is notorious for its health disparities, which include serious mental health deficits, high substance abuse rates, and the lowest average life expectancy in the United States. There has been ongoing concern over the persistent health deficits and social problems in the Delta, which exceed those of some developing countries. While the agricultural economy provides few jobs, the region achieved limited success in diversifying its industries. Due to modern innovations and advanced technological developments, the need for an agricultural workforce has drastically diminished within the past decade. Furthermore, the region has suffered heavy flooding from the MS River flood of 2011.

In addition to the two special populations identified above, an assessment based on existing data, has identified subpopulations that are vulnerable to health disparities. The results of this health disparities assessment revealed significant vulnerabilities among the following groups.

- African Americans
- Mississippi Band of Choctaw Indians
- Sexual/gender minority groups in Mississippi (LGBTQ)
- Adolescents and young adults

Over the past decade, MS has experienced evaluation and technology gaps in collecting LGBT youth data through SmartTrack. The resistance to collecting this data primarily came from the MS Superintendent of Education's Office. However, discussions are currently ongoing and MS has begun collecting LGBT data on 18-25 year-olds through the Young Adult Survey that was developed and pilot-tested by the Evidence Based Workgroup.

All prevention sub-recipients primarily serve the youth and young adult populations and they are required to meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Thus, all sub-recipients must provide culturally appropriate services to diverse populations within the communities they serve. MS is committed to addressing and rectifying disparities in drug and mental health services provided for its adolescents and young adults.

The DMH BADS staff utilizes the following strategies to reduce behavioral health disparities for adolescents and young adults:

1. Collaborate with sub-recipients to continue to identify the types of groups most at risk of health disparities. Mississippi has a documented history of unequal access to social, economic, and health-related resources. Some groups may be influenced by compounded disparities (e.g., Delta residents face a combination of rural remoteness, workforce contraction, and entrenched poverty). As part of this ongoing health disparities assessment, every effort is made to prioritize disparities in terms of their severity and the feasibility of amelioration.
2. Implement interventions in a manner designed to reduce the differences in service availability, access, and use, and to improve prioritized health outcomes among these vulnerable subpopulations.
3. Increase the capacity and readiness of subrecipients' communities to prevent health disparities among identified populations. To do so, all stakeholders are trained on CLAS standards and are required to develop a health disparities impact statement. State staff requires the inclusion of the following goals to be addressed within the disparities impact statements developed by the sub-recipients: (1) increasing participation from sub-populations experiencing disparities on coalitions, advisory boards and workgroups; (2) enhancing strategic partnerships and collaboration that aid in the prevention of disparities among the identified subpopulations; and (3) identifying and implementing strategies related to workforce development and hiring protocols to accommodate diverse cultural health beliefs and practices to support the culture of all subpopulations; (4) providing reasonable accommodations for interpreters and translated materials for preferred languages; and (5) accommodating health literacy and communication needs for subpopulations with limited educational attainment and English proficiency.
4. Participate in focus groups with stakeholders to discuss and to pinpoint best practices with respect to CLAS and to foster the dissemination of such practices. Along with CLAS, disparity data are used to tailor cultural competency policies and practices promoted by the state and infused within the interventions.
5. Integrate a health disparities focus into every step of the SPF model. Key staff, stakeholders, and sub-recipients will continue to improve their capacity to identify disparities, determine their magnitude, pinpoint contributing factors (e.g., barriers), and delineate possible avenues for

overcoming such disparities. Results are used throughout each step of the SPF process to reduce differences and improve outcomes for subpopulations experiencing disparities. Sub-recipients utilize guidance provided by SAMHSA for each step of the SPF as follows.

- *Assessment*: Identify populations vulnerable to behavioral health disparities and the specific disparities experienced within high-need communities
- *Capacity*: Build the capacity of staff, stakeholders, and sub-recipient staff to address disparities, including CLAS standards
- *Planning*: Guide communities on incorporating effective strategies for identifying, addressing, and monitoring disparities among identified populations
- *Implementation*: Implement, and adapt as needed, prevention programs that target identified subpopulations experiencing disparities
- *Evaluation*: Conduct and periodically review process and outcome evaluation data to identify adjustments needed

**Use/Reach.** Using a combination of evaluation instruments and demographic data, disparities as identified by consumption patterns, consequences, and risk/protective factors are tracked and analyzed at the state level, community level, and program level. Three sources of data are used to collect demographic data to monitor the use/reach of the interventions on identified sub-populations: (1) at the state and program levels, demographic information for participants in subrecipient programs collected with DATAGadget™; (2) at the community level, survey data on youth ATOD behavior and attitudes collected annually with SmartTrack™; and (3) at the participant level, ATOD behavior and attitudes of program participants collected with pre/post-test surveys. Data collection for all three of these sources is designed to strictly protect participants' confidentiality and anonymity.

DATAGadget™ is an Internet-based reporting tool that collects process data regarding interventions at the program level. Reports submitted by program administrators using DATAGadget™ include data on the session number, date, duration, and demographic characteristics of program participants. Participation from diverse groups are monitored with process data that includes demographic information. The reporting of these data, however, occurs at the group level with no association being made between the demographic information and individual participants. Participant count data points are reported on an ongoing basis and aggregated to suit federal reporting requirements.

SmartTrack™ is Internet-based survey software that collects and compiles survey responses anonymously. MS has recently revised its SmartTrack survey to identify subpopulations that are especially vulnerable to drug-related problems, including military families, Native Americans, and others. No information collected by SmartTrack™ can be used to identify individual respondents.

Data are collected from program clients in such a manner that health disparities and the reduction of such disparities can be validly measured and carefully monitored. All Mississippi instruments feature items that permit the careful tracking of service delivery and the effectiveness of such services in relation to health disparities.

The Mississippi Young Adult Survey is an instrument tailored specifically to address drug prevention and mental health promotion priorities for Mississippians from ages 18-25. Moreover, this survey captures consumption data (alcohol use, binge drinking, etc.), related risks (suicidality, mental health adversities) and sociodemographic factors (e.g., race, gender, age, sexual orientation) from young adults, particularly those in colleges and universities. Hence, this provides an opportunity for the targeting and tracking of diverse and vulnerable subpopulations across a wide age spectrum.

**Outcomes.** The DMH-BADS team use outcomes associated with the subpopulations identified as experiencing behavioral health disparities to evaluate processes and make programmatic adjustments to address the identified priorities of abuse/misuse of alcohol and prescriptions drugs by persons aged 12 to 25. Process and outcome evaluation analysis, assessment, and monitoring includes a focus on possible disparities in reach, needs and impacts. Therefore, performance indicators are analyzed with attention to gender, race, ethnicity, and LGBT status. Behavioral health disparities that become evident with respect to program processes and outcomes are reported, with recommendations for the amelioration of such disparities conveyed, with recommendations for corrective actions.

The results of the initial assessment revealed significant vulnerabilities among the following groups: African Americans, Mississippi Band of Choctaw Indians, sexual/gender minority groups (LGBT), and residents of the Mississippi Delta and the Gulf Coast. As part of this ongoing health disparities assessment, every effort is be made to prioritize disparities in terms of their severity and the feasibility of amelioration. Gaps in any current data systems and corrective strategies designed to rectify these gaps is also be identified through this ongoing effort.

All stakeholders are trained on the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. DMH understands the 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 should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the services.

**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 assessment 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.

For this table the state needs to:

**1. Identify the needs and gaps of the populations relevant to the SABG within the state's behavioral health care system, especially the priority populations (pregnant women, injecting drug users, women with dependent children, and persons at risk of TB) and any other state specified priority populations.**

- Pregnant Women & Women with Dependent Children
  - Mississippi's female population is 58.3% White alone, not Hispanic, 38.5% African American, 0.4% American Indian, Alaska Native, Native Hawaiian and other Islander, 1% Asian, 1.1% two or more races, and 2.4% Hispanic or Latino (Census 2015). Women, 16 years old and older, make up 48% of Mississippi's work force. Female households make up 26.1% of all households in Mississippi and 11% of these households consist of women with children under 6 years old. The median income for a female household in Mississippi is \$19,048, which is \$7,160 less than the median income of a male household in Mississippi. Approximately 13% of Mississippi women live below the poverty level. Among these impoverished women, about 6% are within the childbearing age range of 15 – 44 years old. In general, women within the childbearing age range make up approximately 40% of Mississippi's population. In Mississippi, 57.6% of women stated their pregnancy was unintended and 88.7% of women were not aware of their pregnancy in their first trimester (MSDH PRAMS 2015). One in three pregnant women reported an income of \$10,000 or less and 3 out of 5 pregnant women

reported an income of \$24,999 or less. More than half of new mothers, 53.5%, in Mississippi reported breastfeeding after delivery. A large number of new mothers, at 73%, reported Medicaid as the form of health insurance used for pregnancy, prenatal care, or delivery. One in six new mothers in Mississippi reported postpartum depressive symptoms. One in six pregnant women in Mississippi reported binge drinking alcohol 3 months before their pregnancy. One in nine women in Mississippi had indicators of pre-pregnancy depression. Over half (64.3%) of women reported that their health care provider discussed procedures for dealing with depression that occurs during and after pregnancy (MSDH PRAMS 2015).

- Mississippi Primary Residential Treatment Programs for pregnant and parenting women consists of twenty-four hour, seven days a week onsite residential program for individuals who have substance use disorders. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive. Primary residential treatment programs operate on a 30-day cycle, on average. This treatment modality consists of withdrawal management; group and individual therapy; family therapy; education/information services explaining alcohol/drug use and dependency; personal growth/self-help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and recreational and social activities. They are also assessed for high risk complications associated with substance use including hepatitis, tuberculosis and HIV/AIDS and provided access to medical services if appropriate. Programs specifically for pregnant women and women with dependent children provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.
- Intensive outpatient programs (IOP) for adults provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week. Programs must include no less than two therapeutic family group sessions during a ten week period to assist with meeting the needs of the individual.
- The Mississippi Department of Mental Health requires that programs deliver a Person-Centered Oriented System of Care, to promote long term recovery through Recovery Support Services. These services are non-clinical services that assist individuals and their families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after

treatment. Recovery support services are provided in conjunction with treatment and/or as separate and distinct services to individuals and families who desire and need them. Recovery support services are delivered by peers, professionals, faith-based and community-based groups, and others designed to help individuals stabilize and sustain their recovery.

- Differences in access and services for population: Women generally seek addiction treatment from physicians and mental health personnel, which may cause a misdiagnosis or mistreatment of their addiction (Jackson and Shannon 2011). Research has indicated that the number of women needing treatment outweighs the number of treatment facilities to provide service, which is definitely the case in Mississippi. The barriers to treatment are different for pregnant women; they fear loss of custody, prosecution, childcare, and lack of services for their prenatal needs. Pregnant women have concerns with the lack of affordability, convenience, availability, and suitability in regards to treating their substance abuse. In rural areas, pregnant women have additional barriers that include transportation, stigma from their community, and financial issues associated with nature of their rural community. Pregnant and parenting women need treatment programs that provide prenatal care, parenting skills, and childcare, which aids in treatment retention and completion of a substance abuse program (Jackson and Shannon 2011).  
Approximately 1 in 8 outpatient-only and residential substance use treatment facilities provided specialized programs to pregnant or parenting women; the number was slightly smaller (7%) for hospital inpatient treatment facilities (Smith and Lipari 2017). A small number of outpatient-only facilities that provided specialized programs to pregnant and parenting women managed an opioid treatment program, at 38%, and fewer provided opioid detoxification services and buprenorphine as a medication assisted treatment, at 25% and 29% respectively. Among the residential treatment facilities that provided specialized programs to pregnant and parenting women, only 4% managed an opioid treatment program, 24% managed opioid detoxification services and 27% buprenorphine as a medication assisted treatment. Approximately 1 in 6 hospital inpatient treatment facilities with specialized programs for pregnant women managed an opioid treatment program, 5 out of 6 provided opioid detoxification services, and 3 out of 5 provided buprenorphine as a medication assisted treatment (Smith and Lipari 2017).
- Differences in outcomes for population: Pregnant women in substance abuse treatment have an increased risk of continuing the behavior of substance abuse due to their difference in characteristics; pregnant women who abuse substances are more likely to have the following characteristics: lower education level, homeless, never married, receive public assistance, lower income, and younger than non-pregnant women who abuse substances (McCabe and Arndt, 2012). Pregnant teenagers have the same high risk characteristics as their adult counterparts that influence their ability to retain a healthy lifestyle (SAMSHA 2013). If a pregnant or postpartum woman has a mood disorder or a high number of psychological stressors then the risk of returning to substance abuse increases (Lander et al., 2015). Pregnant women successfully complete treatment programs less frequently than their non-pregnant counterparts (Sahker et al., 2016). There are many factors that contribute to lack of retention of women and pregnant women in treatment programs. Women are more likely to ask for assistance in a setting

that does not specialize in addiction treatment (Jackson and Shannon, 2011). The referral process is important to retain a pregnant woman's sobriety (Sahker et al., 2016). Pregnant women are more likely to be referred to a treatment program by community organizations or the criminal justice system than reporting themselves to a treatment program (Sahker et al., 2016 & McCabe and Arndt, 2011). The regard of a woman's pregnancy status is necessary to improve the completion rate of treatment, which is predictive of low criminality and relapse (Sahker et al., 2016).

- Improve Disparities: Pregnant and postpartum women admitted to treatment receive intense services geared towards helping them become sober and productive citizens in their communities. These intense services will help women cope with past and current trauma that is hindering them from making positive decisions. This funding opportunity will target those women with the highest need across the state including women involved with the judicial systems and women involved with Child Protection Services as a result of issues related to substance use. Mississippi is a rural and economically disadvantaged state of which many barriers are present including, lack of transportation, lack of close treatment services, lack of childcare, lengthy waiting periods for accessing services, limited number of residential beds and limited number of residential facilities that will accept children. Mississippi ensures those professionals are culturally competent and delivering evidence based practices that are appropriate for the array of cultures (racial, sexuality, etc.) that exist in Mississippi. Mississippi targets African American women as they have been underrepresented in acquiring treatment services due to a vast array of stigma associated with treatment in that culture.

- **Injecting Drug Users**

- According to The World Health Organization, approximately 13 million individuals inject drugs world-wide; those who engage in this risky behavior have a higher risk of HIV and Hepatitis C infections. An estimated 1.7 million intravenous drug users have HIV and people who inject drugs (PWID) account for 67% of all Hepatitis C infections globally. Of the 2.2 million persons who are infected with HIV and Hepatitis, PWIDs account for majority of those cases diagnosed with both illnesses (WHO 2017). In the United States, 2.6% of the population reported injection drug use in their lifetime in 2010 (Lansky et. al, 2014). Males inject drugs more frequently than females over their lifetime in the US. Whites in the US have the highest percentage of lifetime injecting drug use, followed by other races that do not include African Americans or Hispanics. African American and Hispanics reported injection drug use percentage was the same. Americans between the ages of 35 and 49 reported lifetime injection drug use more than any other age group; those aged 50 – 64 and 25 – 34 reported similar frequencies of injection drug use during their lifetime (Lansky et. al, 2014). In 2015, one in fifteen HIV cases was due to injection drug use and one in ten AIDS cases were due to injection drug use (CDC, 2016). Hepatitis C infections increased nearly 3-fold during a 5 year span in the US; from 2010 to 2015, Hepatitis C infections increased each year. The rise in infections was accredited to the rise in injection drug use (CDC, 2015). In Mississippi, 891 individuals reported injection drug use, according to treatment admissions data (MS DMH, 2016). Of those who reported injection drug use, 555 reported injection drug use

as their primary route of drug administration, 230 reported it as a secondary route of drug administration, while 106 reported it as their tertiary route of drug administration.

- Persons at Risk of TB
  - The rate of reported Tuberculosis (TB) cases in Mississippi has decreased in recent years. The rate of TB cases in Mississippi has remained less than the national rate of TB since 2012. In 2016, the rate of TB cases was 2.04 per 100,000 persons, which is less than half of the rate of TB cases in 2002, which were approximately 5 per 100,000 persons. The central-eastern part of Mississippi, which includes the state's capitol and the Mississippi Delta area, represents the majority of the state's TB cases in 2016. In Mississippi, TB cases among African Americans were higher than any other race; they accounted for almost half of the TB cases reported in 2016. Whites accounted for 38% of TB cases and Asians/Pacific Islanders accounted for 13% of TB cases in 2016. During the last year, nearly one in five cases of TB reported in the state was from foreign-born individuals. Since 2011, Mississippians between the ages of 44 and 64 had the highest number of reported cases than any other age group in five of the last 6 years. In 2016, 25 – 64 years old Mississippians represented 55% of all TB cases; individuals aged 25 – 44 represented 34% of those TB cases. In last 10 years, there has been a gender discrepancy in number of TB diagnosis reported in the state. Men represent a larger number of TB diagnoses than women. The rate of TB in HIV positive Mississippians has declined since 2008; however, the number of TB diagnoses is higher in those with HIV than those without the immunodeficiency. In 2016, the percentage of Mississippians that completed their TB treatment declined by 20%. Although the rate of TB cases diagnosed in Mississippi display a downward trend, Mississippians need to improve the adherence to TB treatment.

## 2. Identify the data sources it used to identify the needs and gaps.

Center for Disease Control and Prevention – CDC. (2015). Viral Hepatitis Surveillance, United States, 2015. Retrieved November 2017. <https://www.cdc.gov/hepatitis/statistics/2015surveillance/pdfs/2015HepSurveillanceRpt.pdf>.

Center for Disease Control and Prevention – CDC. (2016). HIV and Injection Drug Use. Retrieved November 2017. <https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-idu-fact-sheet.pdf>

Jackson, A., & Shannon, L. (2012). Barriers to Receiving Substance Abuse Treatment Among Rural Pregnant Women in Kentucky. *Maternal Child Health Journal*, 16, 1762-1770.

Lander, L. R., Gurka, K. K., Marshalek, P. J., Riffon, M., & Sullivan, C. R. (2015). A Comparison of Pregnancy-Only versus Mixed-Gender Group Therapy among Pregnant Women with Opioid Disorder. *Social Work Research*, 39(4), 235-244.

Lansky, A., Finlayson, T., et al. (2014). Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rate of HIV and Hepatitis C Virus Infections. *PLOS ONE*, 9(4), 1-9. Retrieved November 2017. <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0097596&type=printable>.

McCabe, J. E., & Arndt, S. A. (2012). Demographic and Substance Abuse Trends Among Pregnant and Non-Pregnant Women: Eleven Years of Treatment Admission. *Maternal Child Health Journal*, 16, 1696-1702.

MSDH PRAMS (2015) Office of Health Data and Research, Mississippi State Department of Health (MSDH). Mississippi PRAMS Surveillance Report, Year 2011 Births, Jackson, MS: Mississippi Department of Health, 2015.

Sahker, E., McCabe, J. E., & Arndt, S. (2016). Differences in Successful Treatment Completion among Pregnant and Non-pregnant American Women. (19, Ed.) *Archives of Women's Mental Health*, 79-86.

Substance Abuse and Mental Health Services Administration - SAMSHA. (2013). Characteristics of Pregnant Teen Substance Abuse Treatment Admissions. *The Treatment Episode Data Set (TEDS) Report*.

Smith, K., & Lipari, R. (2017). Women of Childbearing Age and Opioids. *The CBHSQ Report*.

U.S. Census. (2015). American Fact Finder. Retrieved June 2017. <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

World Health Organization - WHO. (2017). People Who Inject Drugs. Retrieved November 2017. <http://www.who.int/hiv/topics/idu/about/en/>

### 3. If the state uses a State Epidemiological Outcomes Workgroup (SEOW), describe its composition and contribution to the process for primary prevention and treatment planning.

The Bureau of Alcohol and Drug Services currently uses the State Epidemiological Outcomes Workgroup (SEOW) to gather comprehensive information about the prevalence of alcohol and drug problems throughout Mississippi, for prevention, treatment and recovery support services. The SEOW serves as an important resource in ensuring that all prevention activities and processes are data-driven. Under the leadership of the SEOW Project Director, the Mississippi State Epidemiological Outcomes Workgroup (MS-SEOW) is charged with examining substance use, mental health and related real-time and archival data to monitor trends in substance use, mental health, and related outcomes; determine the scope and magnitude of substance use, mental health, and related outcomes; identify populations at risk and in greater need of mental health and substance abuse services; identify state priorities and provide recommendations for allocating state resources; and evaluate program effectiveness. Mississippi continues to face a number of drug abuse challenges, including the early onset of alcohol use, prescription drug abuse, and adverse

outcomes associated with drug abuse. The SEOW provides a forum for cross-agency collaboration among government leaders, social scientists, prevention experts, and other constituencies throughout the state while also facilitating critical networks in local communities. Through interagency collaboration, the SEOW aims to promote data sharing, training, and cooperation among stakeholders and support efforts to reduce drug abuse and related consequences among Mississippians of all age groups and cultural backgrounds. Consequently, the SEOW is vital for identifying and redressing significant gaps in data collection and coordination among key stakeholders in Mississippi.

The Mississippi SEOW draws membership from various state and local agencies, academic institutions, and community organizations. Represented in the group are the Mississippi Department of Education (MDE), Office of the Attorney General, Mississippi Bureau of Narcotics, Choctaw Behavioral Health, Mississippi Pharmacy Board, Social Science Research Center, and representatives from the various academic institutions across the State. Table 1 provides a list of agencies currently represented in the SEOW.

<b>Table 1. MS SEOW Member Agencies</b>	
MS Attorney General’s Office	MS Department of Health, Office of Tobacco Control
Army One Source	MS Department of Health, Office of Health Data and Statistics
Choctaw Behavioral Health	MS Department of Health, Office of Preventive Health
DREAM of Hattiesburg	MS Department of Mental Health, BADS
Drug Enforcement Agency	MS Division of Medicaid
Independent Evaluators, Univ. of TX- San Antonio	MS National Guard
Jackson State University	MS PDMP, MS Board of Pharmacy
Life Help- Region 6 CMHC	MS Public Health Institute
Mississippi State University, Social Science Research Center	MS Poison Control
Mississippi State University,	MS Department of Public Safety
MS Bureau of Narcotics	National Council on Alcoholism and Drug Dependence
MS Department of Education	Office of the Attorney General, Alcohol and Tobacco Enforcement

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for the collection, analysis, and reporting of substance use incidence, prevalence, related data and Government Performance and Results Act (GPRA) data. These data are, in turn, used by the State and local communities for planning, monitoring, and evaluation purposes. To fulfill its mission, MS-SEOW uses various archival and real-time data. Data Sources used include but are not limited to:

- United States Census
- Mississippi SmartTrack™ Survey, a web-based data collection tool administered annually to Mississippi 6<sup>th</sup>-11<sup>th</sup> graders

- DataGadget™, an internet-based software application for the collection and reporting of process and outcome data by prevention providers
- National Survey on Drug Use and Health (NSDUH)
- Treatment Episodes Data Set (TEDS)
- Youth Risk Behavior Surveillance System (YRBSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS) data from the Department of Public Safety
- Center for Disease Control and Prevention's (CDC) Wide-ranging Online Data for Epidemiologic Research (Wonder)
- County Health Rankings and Roadmaps
- Monitoring the Future
- Kids Count Data Center
- National Poison Data System (NPDS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Mississippi State Department of Health
- Mississippi Bureau of Narcotics
- Mississippi Prescription Drug Monitoring Program

In addition, the SEOW takes advantage of the Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET), which provides a wealth of data on state and national substance use and mental health.

Mississippi's SEOW has been integral to the State's successful implementation of its prevention grants, namely, the SPF SIG, SPE, SABG, PFS II and, most recently, the PFS 2015. The SEOW has been instrumental in determining State priorities and targets for prevention. The SEOW has served as an organizational conduit for data consolidation and dissemination while overseeing the creation of an accessible data platform called Mississippi Snapshots. The SEOW has contributed to MS's Suicide Prevention Grant and MS's first comprehensive suicide prevention plan. The SEOW has also been instrumental in developing the needs assessment for various treatment focused grants, namely, the MS State Youth Treatment Enhancement and Dissemination Project (MS SYT-ED) and the MS State Targeted Response to the Opioid Crisis (MS STR) Grant. The SEOW also contributes to the Substance Abuse State Plan.

One of the SEOW's most significant achievements is the generation, publication, and dissemination of its Epidemiological Profile, an annual state and county-level assessment of youth drug abuse. In addition, the SEOW provides periodic data updates on current and emerging trends in substance use and related outcomes. The SEOW generates its Epidemiological Profile as part of the needs assessment process which the state uses to determine prevention priorities and to identify counties with the highest need for prevention and treatment services. A variety of data sources are reviewed from numerous state and national agencies. Among its other contributions, the Epidemiological Profile documents the burden of alcohol, tobacco, and illicit drug use in Mississippi with the goal of developing strategies to prevent and mitigate these problems. Various sources of data are compiled on users, usage patterns, and the consequences of alcohol, tobacco, and illicit drug use. Although there are many known consequences of alcohol, tobacco, and illicit drug use in Mississippi, there may be others that remain unknown because of a lack of data available in our state. Through the SEOW, the State has identified alcohol, tobacco, marijuana, and prescription drugs as the top four substances of abuse. All of these substances are current prevention targets through the Block Grant. Prescription drug use in particular has been on the rise, ranking second as the most abused illicit drug and fourth as the most reported substance of

abuse among Mississippi adolescents. In 2015, alcohol had the highest reported use at 18%, followed by cigarettes (9%), marijuana (9%) and prescription drugs 4%. Other drug use varied between 2% and 3% (MS SmartTrack™ Survey, 2015).

The SEOW was instrumental in determining underage drinking as a priority for the SPF SIG and, more recently, identifying prescription drug abuse and underage drinking for the Mississippi Partnership Project (SPF PFS II) and the Mississippi Prevention Alliance for Communities and Colleges (SPF PFS 2015). In addition to determining state priorities, the SEOW has provided guidance for the state in identifying populations and communities with the highest need for prevention as well as determining the capacity for communities to implement programs. This process has helped the State in ensuring that resources are allocated where they are most needed and where they have the potential for the greatest impact and the promotion of improved health outcomes.

The SEOW provides the technical expertise to ensure that relevant and appropriate data are available to develop local needs assessments, target programs, assess program effectiveness, and promote evidence-based practices. The SEOW has been involved in the provision of training and guidance to Block Grant and discretionary prevention sub-grantees on building local data capacity; collecting, analyzing and making use of data to support program implementation; and establishing community support for prevention programs. In addition, the SEOW has provided technical expertise in helping sub-grantees to understand their community needs, identifying risk and protective factors, and selecting prevention strategies that best suit the needs of their populations.

**Persistent gaps and challenges.** While the MS-SEOW has made significant progress in facilitating and promoting data-driven processes and decision-making across the state's prevention and treatment systems, significant gaps in data and systems functioning still exist. First, there is a pronounced need to collect data from currently understudied populations, including young adults, LGBTQ youth, and Native American communities. Second, the state still faces technological limitations that prevent local communities from easily accessing data for their community while comparing local usage rates and risk/protective factors with state-level patterns. Third, funding challenges continue to threaten the sustainability of critical surveys, most notably, the Mississippi SmartTrack™ School Survey. And, finally, instrumentation gaps remain, with the state having yet to develop infrastructure assessment tools designed to gauge (a) data system functionality and prospects for systems enhancements, (b) local provider data capacity and paths toward capacity expansion, and (c) barriers to the utilization and dissemination of data analyses along with strategies for overcoming such barriers.

**Step 2: Identify the unmet service needs and critical gaps within the current system.**

Please describe how MS will meet the gaps and needs within the primary prevention system.

In Mississippi, the prevention system is faced with many challenges. One major challenge is that substance abuse prevention lacks state funding. An ideal situation for Mississippi would be that state lawmakers would understand the value of substance abuse prevention and make efforts to support the state prevention infrastructure, financially. Another major challenge that was highlighted in a recent SAMHSA site visit is that the prevention system lacks sufficient staff. The Bureau of Alcohol and Drug Services will be working diligently to increase the staff for prevention services to help manage the many prevention subcontractors and implement the Synar amendment while insuring fidelity. Another challenge that plagues the prevention system is that over half (68%) of the prevention service programs are within community treatment centers. The majority of the treatment centers don't fully support everything that is necessary to successfully implement the six prevention strategies in their communities. These same treatment centers don't value and support the needs of their prevention personnel, which would help them to be more efficient in doing their jobs. The field prevention personnel often detail their challenges of not being valued as an employee, which lead into the next challenge. Due to the prevention workforce having to endure a great deal of obstacles within their agencies, the state has faced a great deal of turnover with prevention specialists and coordinators. At the state level, we invest a great deal of our resources in ensuring that we have a well trained workforce. However, because of the high turnover rates, we aren't seeing a big return on our investment and we constantly have to retrain the new staff on basic concepts. Also, there is often lag time in finding replacement prevention staff and which causes a lag time in reestablishing capacity and rebuilding relationships with those in the

communities. At these same treatment centers, we see that the agencies don't value these employees because they are usually the lowest paid professional staff within the agencies. The low salaries also have an influence on the turnover rates. In MS, our influence is limited because the agencies are independent with their own policies and regulations. However, at the state level, we will continue to advocate for our prevention workforce and intervene whenever possible to improve job satisfaction and the turnover rate. Our new workforce development contractor developed a comprehensive needs assessment through focus groups that revealed a lot of the workforce concerns, needs, and wants. At the state level, we are using the information ascertained from the needs assessment to inform best practices.

One process challenge that plagues MS's prevention system is that we aren't reaching a large percentage of the population with our prevention messages, based on the data that we have been reporting. This was revealed in our recent SAMHSA site visit. Historically, MS prevention system devoted a great deal of focus to prevention education within traditional school settings across Mississippi. In Mississippi, our prevention workforce also focused a great deal of resources on information dissemination. As a result, the MS prevention system is currently in the process of shifting from primarily individual based prevention strategies to more population based prevention strategies in hopes that we will be able to broaden our reach across the state. We will be training our prevention workforce on reaching all of the populations in their communities so that their data are reflective of the populations in their communities. If there are multiple prevention specialists in the same community, we will have them to coordinate their service delivery to better maximize outcomes in reaching the overarching goal of service delivery based on representing the different populations in the community. In MS there are several data gaps that should be noted, we recently began collecting data on the young adult

population but it is only among college students ages 18-25. We have faced challenges with collecting data on the LGBTQ population; however, we did add a question to the young adult survey. In addition, there is not a state evaluation system for the SABG funded sub-recipients and contractors to see if we are achieving the desired changes. In Mississippi, we are currently exploring feasible options for acquiring an evaluator. One challenge that plagues our prevention infrastructure is that we have been funding prevention based on the providers' historical allocation. We want to shift from this method to a fee for service process to ensure that allocations are fair and representative of the work that is being done.

### **3. Address how these systems address the needs of diverse, racial, ethnic and gender minorities as well as youth who are often underserved.**

The state of Mississippi (MS) has a very diverse population compared to other states. The majority of the population or 59.8% consists of Caucasians. African Americans account for 37.4% of the population, which is the highest percentage of African Americans among the fifty states in the US, according to the US Census. American Indians and Alaska Natives account for .6%; Asians account for 1%; Native Hawaiians and Other Pacific Islander account for .1%; Historically, Mississippi has been a socio-economically challenged state because of the high levels of poverty combined with lower educational attainment for those economically challenged. The MS Department of Mental Health defines Cultural Competency as the acceptance and respect for difference, continuing self-assessment regarding culture, attention to dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations.

Activities implemented under the auspices of the public behavioral health system are developed and conducted in a manner that respects the cultural distinctiveness and diversity of those served by the local community mental health centers and prevention agencies throughout the state of Mississippi (MS). The MS Department of Mental Health's Bureau of Alcohol and Drug Services staff itself is culturally diverse and has extensive experience implementing programs to socially disadvantaged populations in a culturally competent fashion. All certified and funded providers are required to place an emphasis on language and literacy, and accommodate all individuals regardless of race, ethnicity, sexual orientation, gender identity and disability. In the MS Department of Mental Health's Operational Standards it states that "Providers must put in place quality management strategies that at a minimum: collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services"; "At a minimum, general orientation must address the following area: Family/Cultural Issues and Respecting Cultural Differences"; "There must be written and implemented policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal representative(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. These rights are applicable to all individuals receiving services except for individuals that have been civilly committed or individuals who are confined to a correctional facility. The individual receiving services and/or parent/legal representative must also be given a written copy of these rights, which at a minimum, must include: The services within the program and other services available regardless of cultural barriers and limited English proficiency"; "A. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services. A detailed description of when and how these services will be provided must be clearly explained in the provider's policies and procedures. B. All providers must develop and implement policies and procedures that address

Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Human Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. All policies and procedures must include the following. 1. The process for offering 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 services. 2. How the agency informs individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. 3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. 4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the population in the service area. C. Cultural competence describes the ability of an agency to provide services to individuals with diverse values, beliefs, and behaviors, including tailoring service delivery to meet the individual's social, cultural and linguistic needs. Policies and procedure manual must

reflect the agency's efforts to integrate values, attitudes and beliefs of the individuals served into the services provided"; "Services and programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized for each individual receiving service"; "Services and plan development must reflect cultural considerations of the individual and be conducted by providing information in a plain language and in a manner that is accessible to the individuals and persons who have limited English proficiency";

MS has identified two special populations as defined by geographical regions: (1) the MS Gulf Coast and (2) the Mississippi Delta. Populations in these geographical regions have demonstrated persistent and elevated vulnerability to the substance use risks and contributing factors prioritized by the Substance Abuse Block Grant.

Substance use and mental health problems exhibited along the Gulf Coast have been compounded by Hurricane Katrina and the Deepwater Horizon oil spill. These disasters represented a loss of social and economic support for many community residents, leading to an increase in adverse mental health conditions. The behavioral health status of residents plummeted following Hurricane Katrina, and is strongly suspected to have contributed to increasing problems with substance abuse and dependence, psychiatric disorders, and familial breakdown, including divorce and domestic violence. The social impact and aftermath of Hurricane Katrina has been identified as one of the most severe humanitarian crises in U.S. history. Youth were not immune from the widespread symptoms of depression and posttraumatic stress brought about by Hurricane Katrina. For many youth, separation from a caregiver was coupled with temporary housing only to be followed by relocation to trailers. Many residents lost loved ones as their possessions were gone and their communities were leveled.

Youth are among those most severely affected by mental distress after a disaster and often exhibit long-lasting adverse effects such as future domestic abuse, suicidal ideation, criminal behavior, and drug dependence/abuse. A comprehensive report, *The Children's First Annual* (2012), indicates that the Gulf Coast region is in desperate need of assistance to combat unusually elevated school dropout rates, large percentages of children living in poverty, and lackluster educational aspirations among youth. These problems have been especially pervasive in Hancock County, where school assessments and screeners show a marked increase in drug use, drug dependence, depression, anxiety, and suicidal ideation. As such, it is crucial to continue to provide support and services to address the needs of this community.

Second, the MS Delta region, is marked by several racial, cultural, and economic disadvantages. The Delta is notorious for its health disparities, which include serious mental health deficits, high substance abuse rates, and the lowest average life expectancy in the United States. There has been ongoing concern over the persistent health deficits and social problems in the Delta, which exceed those of some developing countries. While the agricultural economy provides few jobs, the region achieved limited success in diversifying its industries. Due to modern innovations and advanced technological developments, the need for an agricultural workforce has drastically diminished within the past decade. Furthermore, the region has suffered heavy flooding from the MS River flood of 2011.

In addition to the two special populations identified above, an assessment based on existing data, has identified subpopulations that are vulnerable to health disparities. The results of this health disparities assessment revealed significant vulnerabilities among the following groups.

- African Americans
- Mississippi Band of Choctaw Indians
- Sexual/gender minority groups in Mississippi (LGBTQ)
- Adolescents and young adults

Over the past decade, MS has experienced evaluation and technology gaps in collecting LGBT youth data through SmartTrack. The resistance to collecting this data primarily came from the MS Superintendent of Education's Office. However, discussions are currently ongoing and MS has begun collecting LGBT data on 18-25 year-olds through the Young Adult Survey that was developed and pilot-tested by the Evidence Based Workgroup.

All prevention sub-recipients primarily serve the youth and young adult populations and they are required to meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Thus, all sub-recipients must provide culturally appropriate services to diverse populations within the communities they serve. MS is committed to addressing and rectifying disparities in drug and mental health services provided for its adolescents and young adults.

The DMH BADS staff utilizes the following strategies to reduce behavioral health disparities for adolescents and young adults:

1. Collaborate with sub-recipients to continue to identify the types of groups most at risk of health disparities. Mississippi has a documented history of unequal access to social, economic, and health-related resources. Some groups may be influenced by compounded disparities (e.g., Delta residents face a combination of rural remoteness, workforce contraction, and entrenched poverty). As part of this ongoing health disparities assessment, every effort is made to prioritize disparities in terms of their severity and the feasibility of amelioration.
2. Implement interventions in a manner designed to reduce the differences in service availability, access, and use, and to improve prioritized health outcomes among these vulnerable subpopulations.
3. Increase the capacity and readiness of subrecipients' communities to prevent health disparities among identified populations. To do so, all stakeholders are trained on CLAS standards and are required to develop a health disparities impact statement. State staff requires the inclusion of the following goals to be addressed within the disparities impact statements developed by the sub-recipients: (1) increasing participation from sub-populations experiencing disparities on coalitions, advisory boards and workgroups; (2) enhancing strategic partnerships and collaboration that aid in the prevention of disparities among the identified subpopulations; and (3) identifying and implementing strategies related to workforce development and hiring protocols to accommodate diverse cultural health beliefs and practices to support the culture of all subpopulations; (4) providing reasonable accommodations for interpreters and translated materials for preferred languages; and (5) accommodating health literacy and communication needs for subpopulations with limited educational attainment and English proficiency.
4. Participate in focus groups with stakeholders to discuss and to pinpoint best practices with respect to CLAS and to foster the dissemination of such practices. Along with CLAS, disparity data are used to tailor cultural competency policies and practices promoted by the state and infused within the interventions.
5. Integrate a health disparities focus into every step of the SPF model. Key staff, stakeholders, and sub-recipients will continue to improve their capacity to identify disparities, determine their magnitude, pinpoint contributing factors (e.g., barriers), and delineate possible avenues for

overcoming such disparities. Results are used throughout each step of the SPF process to reduce differences and improve outcomes for subpopulations experiencing disparities. Sub-recipients utilize guidance provided by SAMHSA for each step of the SPF as follows.

- *Assessment*: Identify populations vulnerable to behavioral health disparities and the specific disparities experienced within high-need communities
- *Capacity*: Build the capacity of staff, stakeholders, and sub-recipient staff to address disparities, including CLAS standards
- *Planning*: Guide communities on incorporating effective strategies for identifying, addressing, and monitoring disparities among identified populations
- *Implementation*: Implement, and adapt as needed, prevention programs that target identified subpopulations experiencing disparities
- *Evaluation*: Conduct and periodically review process and outcome evaluation data to identify adjustments needed

**Use/Reach.** Using a combination of evaluation instruments and demographic data, disparities as identified by consumption patterns, consequences, and risk/protective factors are tracked and analyzed at the state level, community level, and program level. Three sources of data are used to collect demographic data to monitor the use/reach of the interventions on identified sub-populations: (1) at the state and program levels, demographic information for participants in subrecipient programs collected with DATAGadget™; (2) at the community level, survey data on youth ATOD behavior and attitudes collected annually with SmartTrack™; and (3) at the participant level, ATOD behavior and attitudes of program participants collected with pre/post-test surveys. Data collection for all three of these sources is designed to strictly protect participants' confidentiality and anonymity.

DATAGadget™ is an Internet-based reporting tool that collects process data regarding interventions at the program level. Reports submitted by program administrators using DATAGadget™ include data on the session number, date, duration, and demographic characteristics of program participants. Participation from diverse groups are monitored with process data that includes demographic information. The reporting of these data, however, occurs at the group level with no association being made between the demographic information and individual participants. Participant count data points are reported on an ongoing basis and aggregated to suit federal reporting requirements.

SmartTrack™ is Internet-based survey software that collects and compiles survey responses anonymously. MS has recently revised its SmartTrack survey to identify subpopulations that are especially vulnerable to drug-related problems, including military families, Native Americans, and others. No information collected by SmartTrack™ can be used to identify individual respondents.

Data are collected from program clients in such a manner that health disparities and the reduction of such disparities can be validly measured and carefully monitored. All Mississippi instruments feature items that permit the careful tracking of service delivery and the effectiveness of such services in relation to health disparities.

The Mississippi Young Adult Survey is an instrument tailored specifically to address drug prevention and mental health promotion priorities for Mississippians from ages 18-25. Moreover, this survey captures consumption data (alcohol use, binge drinking, etc.), related risks (suicidality, mental health adversities) and sociodemographic factors (e.g., race, gender, age, sexual orientation) from young adults, particularly those in colleges and universities. Hence, this provides an opportunity for the targeting and tracking of diverse and vulnerable subpopulations across a wide age spectrum.

**Outcomes.** The DMH-BADS team use outcomes associated with the subpopulations identified as experiencing behavioral health disparities to evaluate processes and make programmatic adjustments to address the identified priorities of abuse/misuse of alcohol and prescriptions drugs by persons aged 12 to 25. Process and outcome evaluation analysis, assessment, and monitoring includes a focus on possible disparities in reach, needs and impacts. Therefore, performance indicators are analyzed with attention to gender, race, ethnicity, and LGBT status. Behavioral health disparities that become evident with respect to program processes and outcomes are reported, with recommendations for the amelioration of such disparities conveyed, with recommendations for corrective actions.

The results of the initial assessment revealed significant vulnerabilities among the following groups: African Americans, Mississippi Band of Choctaw Indians, sexual/gender minority groups (LGBT), and residents of the Mississippi Delta and the Gulf Coast. As part of this ongoing health disparities assessment, every effort is be made to prioritize disparities in terms of their severity and the feasibility of amelioration. Gaps in any current data systems and corrective strategies designed to rectify these gaps is also be identified through this ongoing effort.

All stakeholders are trained on the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. DMH understands the 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 should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the services.

**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 assessment 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.

For this table the state needs to:

**1. Identify the needs and gaps of the populations relevant to the SABG within the state's behavioral health care system, especially the priority populations (pregnant women, injecting drug users, women with dependent children, and persons at risk of TB) and any other state specified priority populations.**

- **Pregnant Women & Women with Dependent Children**
  - Mississippi's female population is 58.3% White alone, not Hispanic, 38.5% African American, 0.4% American Indian, Alaska Native, Native Hawaiian and other Islander, 1% Asian, 1.1% two or more races, and 2.4% Hispanic or Latino (Census 2015). Women, 16 years old and older, make up 48% of Mississippi's work force. Female households make up 26.1% of all households in Mississippi and 11% of these households consist of women with children under 6 years old. The median income for a female household in Mississippi is \$19,048, which is \$7,160 less than the median income of a male household in Mississippi. Approximately 13% of Mississippi women live below the poverty level. Among these impoverished women, about 6% are within the childbearing age range of 15 – 44 years old. In general, women within the childbearing age range make up approximately 40% of Mississippi's population. In Mississippi, 57.6% of women stated their pregnancy was unintended and 88.7% of women were not aware of their pregnancy in their first trimester (MSDH PRAMS 2015). One in three pregnant women reported an income of \$10,000 or less and 3 out of 5 pregnant women

reported an income of \$24,999 or less. More than half of new mothers, 53.5%, in Mississippi reported breastfeeding after delivery. A large number of new mothers, at 73%, reported Medicaid as the form of health insurance used for pregnancy, prenatal care, or delivery. One in six new mothers in Mississippi reported postpartum depressive symptoms. One in six pregnant women in Mississippi reported binge drinking alcohol 3 months before their pregnancy. One in nine women in Mississippi had indicators of pre-pregnancy depression. Over half (64.3%) of women reported that their health care provider discussed procedures for dealing with depression that occurs during and after pregnancy (MSDH PRAMS 2015).

- Mississippi Primary Residential Treatment Programs for pregnant and parenting women consists of twenty-four hour, seven days a week onsite residential program for individuals who have substance use disorders. This type of treatment is prescribed for those who lack sufficient motivation and/or social support to remain abstinent in a setting less restrictive. Primary residential treatment programs operate on a 30-day cycle, on average. This treatment modality consists of withdrawal management; group and individual therapy; family therapy; education/information services explaining alcohol/drug use and dependency; personal growth/self-help skills; relapse prevention; coping skills/anger management and the recovery process; vocational counseling and rehabilitation services; employment activities; and recreational and social activities. They are also assessed for high risk complications associated with substance use including hepatitis, tuberculosis and HIV/AIDS and provided access to medical services if appropriate. Programs specifically for pregnant women and women with dependent children provide pre/post-natal care to pregnant women throughout the treatment process and afford infants/young children the opportunity to remain with their mothers. The treatment program also focuses on parenting skills education, nutrition, medical and other needed services.
- Intensive outpatient programs (IOP) for adults provides an alternative to traditional residential or hospital settings. It is directed to persons whose substance use problems are of a severity that require treatment services of a more intensive level than general outpatient but less severe than those typically addressed in residential or inpatient treatment programs. The IOP allows the client to continue to fulfill his/her obligations to family, job, and community while obtaining treatment. Typically, the IOP provides 3-hour group therapy sessions, which are conducted at least three times per week for at least ten to fifteen weeks. Individual therapy sessions are also provided to each individual at least once per week. Programs must include no less than two therapeutic family group sessions during a ten week period to assist with meeting the needs of the individual.
- The Mississippi Department of Mental Health requires that programs deliver a Person-Centered Oriented System of Care, to promote long term recovery through Recovery Support Services. These services are non-clinical services that assist individuals and their families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after

treatment. Recovery support services are provided in conjunction with treatment and/or as separate and distinct services to individuals and families who desire and need them. Recovery support services are delivered by peers, professionals, faith-based and community-based groups, and others designed to help individuals stabilize and sustain their recovery.

- Differences in access and services for population: Women generally seek addiction treatment from physicians and mental health personnel, which may cause a misdiagnosis or mistreatment of their addiction (Jackson and Shannon 2011). Research has indicated that the number of women needing treatment outweighs the number of treatment facilities to provide service, which is definitely the case in Mississippi. The barriers to treatment are different for pregnant women; they fear loss of custody, prosecution, childcare, and lack of services for their prenatal needs. Pregnant women have concerns with the lack of affordability, convenience, availability, and suitability in regards to treating their substance abuse. In rural areas, pregnant women have additional barriers that include transportation, stigma from their community, and financial issues associated with nature of their rural community. Pregnant and parenting women need treatment programs that provide prenatal care, parenting skills, and childcare, which aids in treatment retention and completion of a substance abuse program (Jackson and Shannon 2011).  
Approximately 1 in 8 outpatient-only and residential substance use treatment facilities provided specialized programs to pregnant or parenting women; the number was slightly smaller (7%) for hospital inpatient treatment facilities (Smith and Lipari 2017). A small number of outpatient-only facilities that provided specialized programs to pregnant and parenting women managed an opioid treatment program, at 38%, and fewer provided opioid detoxification services and buprenorphine as a medication assisted treatment, at 25% and 29% respectively. Among the residential treatment facilities that provided specialized programs to pregnant and parenting women, only 4% managed an opioid treatment program, 24% managed opioid detoxification services and 27% buprenorphine as a medication assisted treatment. Approximately 1 in 6 hospital inpatient treatment facilities with specialized programs for pregnant women managed an opioid treatment program, 5 out of 6 provided opioid detoxification services, and 3 out of 5 provided buprenorphine as a medication assisted treatment (Smith and Lipari 2017).
- Differences in outcomes for population: Pregnant women in substance abuse treatment have an increased risk of continuing the behavior of substance abuse due to their difference in characteristics; pregnant women who abuse substances are more likely to have the following characteristics: lower education level, homeless, never married, receive public assistance, lower income, and younger than non-pregnant women who abuse substances (McCabe and Arndt, 2012). Pregnant teenagers have the same high risk characteristics as their adult counterparts that influence their ability to retain a healthy lifestyle (SAMSHA 2013). If a pregnant or postpartum woman has a mood disorder or a high number of psychological stressors then the risk of returning to substance abuse increases (Lander et al., 2015). Pregnant women successfully complete treatment programs less frequently than their non-pregnant counterparts (Sahker et al., 2016). There are many factors that contribute to lack of retention of women and pregnant women in treatment programs. Women are more likely to ask for assistance in a setting

that does not specialize in addiction treatment (Jackson and Shannon, 2011). The referral process is important to retain a pregnant woman's sobriety (Sahker et al., 2016). Pregnant women are more likely to be referred to a treatment program by community organizations or the criminal justice system than reporting themselves to a treatment program (Sahker et al., 2016 & McCabe and Arndt, 2011). The regard of a woman's pregnancy status is necessary to improve the completion rate of treatment, which is predictive of low criminality and relapse (Sahker et al., 2016).

- Improve Disparities: Pregnant and postpartum women admitted to treatment receive intense services geared towards helping them become sober and productive citizens in their communities. These intense services will help women cope with past and current trauma that is hindering them from making positive decisions. This funding opportunity will target those women with the highest need across the state including women involved with the judicial systems and women involved with Child Protection Services as a result of issues related to substance use. Mississippi is a rural and economically disadvantaged state of which many barriers are present including, lack of transportation, lack of close treatment services, lack of childcare, lengthy waiting periods for accessing services, limited number of residential beds and limited number of residential facilities that will accept children. Mississippi ensures those professionals are culturally competent and delivering evidence based practices that are appropriate for the array of cultures (racial, sexuality, etc.) that exist in Mississippi. Mississippi targets African American women as they have been underrepresented in acquiring treatment services due to a vast array of stigma associated with treatment in that culture.

- **Injecting Drug Users**

- According to The World Health Organization, approximately 13 million individuals inject drugs world-wide; those who engage in this risky behavior have a higher risk of HIV and Hepatitis C infections. An estimated 1.7 million intravenous drug users have HIV and people who inject drugs (PWID) account for 67% of all Hepatitis C infections globally. Of the 2.2 million persons who are infected with HIV and Hepatitis, PWIDs account for majority of those cases diagnosed with both illnesses (WHO 2017). In the United States, 2.6% of the population reported injection drug use in their lifetime in 2010 (Lansky et. al, 2014). Males inject drugs more frequently than females over their lifetime in the US. Whites in the US have the highest percentage of lifetime injecting drug use, followed by other races that do not include African Americans or Hispanics. African American and Hispanics reported injection drug use percentage was the same. Americans between the ages of 35 and 49 reported lifetime injection drug use more than any other age group; those aged 50 – 64 and 25 – 34 reported similar frequencies of injection drug use during their lifetime (Lansky et. al, 2014). In 2015, one in fifteen HIV cases was due to injection drug use and one in ten AIDS cases were due to injection drug use (CDC, 2016). Hepatitis C infections increased nearly 3-fold during a 5 year span in the US; from 2010 to 2015, Hepatitis C infections increased each year. The rise in infections was accredited to the rise in injection drug use (CDC, 2015). In Mississippi, 891 individuals reported injection drug use, according to treatment admissions data (MS DMH, 2016). Of those who reported injection drug use, 555 reported injection drug use

as their primary route of drug administration, 230 reported it as a secondary route of drug administration, while 106 reported it as their tertiary route of drug administration.

- Persons at Risk of TB

- The rate of reported Tuberculosis (TB) cases in Mississippi has decreased in recent years. The rate of TB cases in Mississippi has remained less than the national rate of TB since 2012. In 2016, the rate of TB cases was 2.04 per 100,000 persons, which is less than half of the rate of TB cases in 2002, which were approximately 5 per 100,000 persons. The central-eastern part of Mississippi, which includes the state's capitol and the Mississippi Delta area, represents the majority of the state's TB cases in 2016. In Mississippi, TB cases among African Americans were higher than any other race; they accounted for almost half of the TB cases reported in 2016. Whites accounted for 38% of TB cases and Asians/Pacific Islanders accounted for 13% of TB cases in 2016. During the last year, nearly one in five cases of TB reported in the state was from foreign-born individuals. Since 2011, Mississippians between the ages of 44 and 64 had the highest number of reported cases than any other age group in five of the last 6 years. In 2016, 25 – 64 years old Mississippians represented 55% of all TB cases; individuals aged 25 – 44 represented 34% of those TB cases. In last 10 years, there has been a gender discrepancy in number of TB diagnosis reported in the state. Men represent a larger number of TB diagnoses than women. The rate of TB in HIV positive Mississippians has declined since 2008; however, the number of TB diagnoses is higher in those with HIV than those without the immunodeficiency. In 2016, the percentage of Mississippians that completed their TB treatment declined by 20%. Although the rate of TB cases diagnosed in Mississippi display a downward trend, Mississippians need to improve the adherence to TB treatment.

- Persons at Risk for HIV

The MS State Department of Health, Bureau of STD/HIV reported that in 2014 there were 487 newly diagnosed cases of HIV disease. The majority (380 or 78%) of the cases were African American while 81 (16.6%) were Caucasian. Persons living with HIV/AIDS in Mississippi in 2013 totaled 10,473. In 2013, there were 7,552 (72.1%) individuals of African American descent living in MS with HIV. This is particularly important to note since African Americans represent only 37.4% of MS's general population (Census, 2013). In 2013, there were 2,309 (22%) individuals of Caucasians descent living in MS with HIV. Out of the 82 counties in MS, the top seven counties in 2013 which had persons living with HIV were: Hinds (2,631), Harrison (774), Rankin (567), Forrest (413), DeSoto (357), Jackson (330), and Lauderdale (276).

2. Identify the data sources it used to identify the needs and gaps.

Center for Disease Control and Prevention – CDC. (2015). Viral Hepatitis Surveillance, United States, 2015. Retrieved November 2017. <https://www.cdc.gov/hepatitis/statistics/2015surveillance/pdfs/2015HepSurveillanceRpt.pdf>.

Center for Disease Control and Prevention – CDC. (2016). HIV and Injection Drug Use. Retrieved November 2017. <https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-idu-fact-sheet.pdf>

Jackson, A., & Shannon, L. (2012). Barriers to Receiving Substance Abuse Treatment Among Rural Pregnant Women in Kentucky. *Maternal Child Health Journal*, 16, 1762-1770.

Lander, L. R., Gurka, K. K., Marshalek, P. J., Riffon, M., & Sullivan, C. R. (2015). A Comparison of Pregnancy-Only versus Mixed-Gender Group Therapy among Pregnant Women with Opioid Disorder. *Social Work Research*, 39(4), 235-244.

Lansky, A., Finlayson, T., et al. (2014). Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rate of HIV and Hepatitis C Virus Infections. *PLOS ONE*, 9(4), 1-9. Retrieved November 2017. <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0097596&type=printable>.

McCabe, J. E., & Arndt, S. A. (2012). Demographic and Substance Abuse Trends Among Pregnant and Non-Pregnant Women: Eleven Years of Treatment Admission. *Maternal Child Health Journal*, 16, 1696-1702.

MSDH PRAMS (2015) Office of Health Data and Research, Mississippi State Department of Health (MSDH). Mississippi PRAMS Surveillance Report, Year 2011 Births, Jackson, MS: Mississippi Department of Health, 2015.

Sahker, E., McCabe, J. E., & Arndt, S. (2016). Differences in Successful Treatment Completion among Pregnant and Non-pregnant American Women. (19, Ed.) *Archives of Women's Mental Health*, 79-86.

Substance Abuse and Mental Health Services Administration - SAMSHA. (2013). Characteristics of Pregnant Teen Substance Abuse Treatment Admissions. *The Treatment Episode Data Set (TEDS) Report*.

Smith, K., & Lipari, R. (2017). Women of Childbearing Age and Opioids. *The CBHSQ Report*.

U.S. Census. (2015). American Fact Finder. Retrieved June 2017. <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

World Health Organization - WHO. (2017). People Who Inject Drugs. Retrieved November 2017.  
<http://www.who.int/hiv/topics/idu/about/en/>

3. If the state uses a State Epidemiological Outcomes Workgroup (SEOW), describe its composition and contribution to the process for primary prevention and treatment planning.

The Bureau of Alcohol and Drug Services currently uses the State Epidemiological Outcomes Workgroup (SEOW) to gather comprehensive information about the prevalence of alcohol and drug problems throughout Mississippi, for prevention, treatment and recovery support services. The SEOW serves as an important resource in ensuring that all prevention activities and processes are data-driven. Under the leadership of the SEOW Project Director, the Mississippi State Epidemiological Outcomes Workgroup (MS-SEOW) is charged with examining substance use, mental health and related real-time and archival data to monitor trends in substance use, mental health, and related outcomes; determine the scope and magnitude of substance use, mental health, and related outcomes; identify populations at risk and in greater need of mental health and substance abuse services; identify state priorities and provide recommendations for allocating state resources; and evaluate program effectiveness. Mississippi continues to face a number of drug abuse challenges, including the early onset of alcohol use, prescription drug abuse, and adverse outcomes associated with drug abuse. The SEOW provides a forum for cross-agency collaboration among government leaders, social scientists, prevention experts, and other constituencies throughout the state while also facilitating critical networks in local communities. Through interagency collaboration, the SEOW aims to promote data sharing, training, and cooperation among stakeholders and support efforts to reduce drug abuse and related consequences among Mississippians of all age groups and cultural backgrounds. Consequently, the SEOW is vital for identifying and redressing significant gaps in data collection and coordination among key stakeholders in Mississippi.

The Mississippi SEOW draws membership from various state and local agencies, academic institutions, and community organizations. Represented in the group are the Mississippi Department of Education (MDE), Office of the Attorney General, Mississippi Bureau of Narcotics, Choctaw Behavioral Health, Mississippi Pharmacy Board, Social Science Research Center, and representatives from the various academic institutions across the State. Table 1 provides a list of agencies currently represented in the SEOW.

<b>Table 1. MS SEOW Member Agencies</b>	
MS Attorney General's Office	MS Department of Health, Office of Tobacco Control
Army One Source	MS Department of Health, Office of Health Data and Statistics
Choctaw Behavioral Health	MS Department of Health, Office of Preventive Health
DREAM of Hattiesburg	MS Department of Mental Health, BADS
Drug Enforcement Agency	MS Division of Medicaid
Independent Evaluators, Univ. of TX- San Antonio	MS National Guard
Jackson State University	MS PDMP, MS Board of Pharmacy
Life Help- Region 6 CMHC	MS Public Health Institute
Mississippi State University, Social Science Research Center	MS Poison Control

Mississippi State University,	MS Department of Public Safety
MS Bureau of Narcotics	National Council on Alcoholism and Drug Dependence
MS Department of Education	Office of the Attorney General, Alcohol and Tobacco Enforcement

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for the collection, analysis, and reporting of substance use incidence, prevalence, related data and Government Performance and Results Act (GPRA) data. These data are, in turn, used by the State and local communities for planning, monitoring, and evaluation purposes. To fulfill its mission, MS-SEOW uses various archival and real-time data. Data Sources used include but are not limited to:

- United States Census
- Mississippi SmartTrack™ Survey, a web-based data collection tool administered annually to Mississippi 6<sup>th</sup>-11<sup>th</sup> graders
- DataGadget™, an internet-based software application for the collection and reporting of process and outcome data by prevention providers
- National Survey on Drug Use and Health (NSDUH)
- Treatment Episodes Data Set (TEDS)
- Youth Risk Behavior Surveillance System (YRBSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS) data from the Department of Public Safety
- Center for Disease Control and Prevention’s (CDC) Wide-ranging Online Data for Epidemiologic Research (Wonder)
- County Health Rankings and Roadmaps
- Monitoring the Future
- Kids Count Data Center
- National Poison Data System (NPDS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Mississippi State Department of Health
- Mississippi Bureau of Narcotics
- Mississippi Prescription Drug Monitoring Program

In addition, the SEOW takes advantage of the Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET), which provides a wealth of data on state and national substance use and mental health.

Mississippi’s SEOW has been integral to the State’s successful implementation of its prevention grants, namely, the SPF SIG, SPE, SABG, PFS II and, most recently, the PFS 2015. The SEOW has been instrumental in determining State priorities and targets for prevention. The SEOW has served as an organizational conduit for data consolidation and dissemination while overseeing the creation of an accessible data platform called Mississippi Snapshots. The SEOW has contributed to MS’s Suicide Prevention Grant and MS’s first comprehensive suicide prevention plan. The SEOW has also been instrumental in developing the needs assessment for various treatment focused grants, namely, the MS State Youth Treatment Enhancement and Dissemination Project (MS SYT-ED) and the MS State Targeted Response to the Opioid Crisis (MS STR) Grant. The SEOW also contributes to the Substance Abuse State Plan.

One of the SEOW's most significant achievements is the generation, publication, and dissemination of its Epidemiological Profile, an annual state and county-level assessment of youth drug abuse. In addition, the SEOW provides periodic data updates on current and emerging trends in substance use and related outcomes. The SEOW generates its Epidemiological Profile as part of the needs assessment process which the state uses to determine prevention priorities and to identify counties with the highest need for prevention and treatment services. A variety of data sources are reviewed from numerous state and national agencies. Among its other contributions, the Epidemiological Profile documents the burden of alcohol, tobacco, and illicit drug use in Mississippi with the goal of developing strategies to prevent and mitigate these problems. Various sources of data are compiled on users, usage patterns, and the consequences of alcohol, tobacco, and illicit drug use. Although there are many known consequences of alcohol, tobacco, and illicit drug use in Mississippi, there may be others that remain unknown because of a lack of data available in our state. Through the SEOW, the State has identified alcohol, tobacco, marijuana, and prescription drugs as the top four substances of abuse. All of these substances are current prevention targets through the Block Grant. Prescription drug use in particular has been on the rise, ranking second as the most abused illicit drug and fourth as the most reported substance of abuse among Mississippi adolescents. In 2015, alcohol had the highest reported use at 18%, followed by cigarettes (9%), marijuana (9%) and prescription drugs 4%. Other drug use varied between 2% and 3% (MS SmartTrack™ Survey, 2015).

The SEOW was instrumental in determining underage drinking as a priority for the SPF SIG and, more recently, identifying prescription drug abuse and underage drinking for the Mississippi Partnership Project (SPF PFS II) and the Mississippi Prevention Alliance for Communities and Colleges (SPF PFS 2015). In addition to determining state priorities, the SEOW has provided guidance for the state in identifying populations and communities with the highest need for prevention as well as determining the capacity for communities to implement programs. This process has helped the State in ensuring that resources are allocated where they are most needed and where they have the potential for the greatest impact and the promotion of improved health outcomes.

The SEOW provides the technical expertise to ensure that relevant and appropriate data are available to develop local needs assessments, target programs, assess program effectiveness, and promote evidence-based practices. The SEOW has been involved in the provision of training and guidance to Block Grant and discretionary prevention sub-grantees on building local data capacity; collecting, analyzing and making use of data to support program implementation; and establishing community support for prevention programs. In addition, the SEOW has provided technical expertise in helping sub-grantees to understand their community needs, identifying risk and protective factors, and selecting prevention strategies that best suit the needs of their populations.

**Persistent gaps and challenges.** While the MS-SEOW has made significant progress in facilitating and promoting data-driven processes and decision-making across the state's prevention and treatment systems, significant gaps in data and systems functioning still exist. First, there is a pronounced need to

collect data from currently understudied populations, including young adults, LGBTQ youth, and Native American communities. Second, the state still faces technological limitations that prevent local communities from easily accessing data for their community while comparing local usage rates and risk/protective factors with state-level patterns. Third, funding challenges continue to threaten the sustainability of critical surveys, most notably, the Mississippi SmartTrack™ School Survey. And, finally, instrumentation gaps remain, with the state having yet to develop infrastructure assessment tools designed to gauge (a) data system functionality and prospects for systems enhancements, (b) local provider data capacity and paths toward capacity expansion, and (c) barriers to the utilization and dissemination of data analyses along with strategies for overcoming such barriers.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

---

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

*Please indicate areas of technical assistance needed related to this section.*

**Footnotes:**

We are requesting assistance from SAMHSA as we move toward a new data system for DMH.

Mississippi utilizes Data Gadget to capture indicators focused around the Center for Substance Abuse Prevention strategies. Data Gadget is currently used to capture data on processes and outcomes for prevention across the state. Prevention education and environmental strategies outcomes are reported to Data Gadget by sub-grantees. Sub-grantees are able to report on the program base, intervention type, universal type, program type (evidence based or approved), state approved or NREPP, program name, group name, service location, and the statewide initiatives targeted (marijuana use by adolescents, merchant education, prescription drug abuse, underage drinking). Sub-grantees are also able to report the demographics (gender, ethnicity, and race) for the population receiving the intervention services. All participant level data are captured by Data Gadget on current substance use, disapproval attitudes related to substance use, and perception of risk related to substance use. Data Gadget also captures some risk and protective measures including driving while under the influence or riding with someone who's under the influence of substances, discussing dangers or problems with substances use, employer drug testing, and suicidal ideation factors (feeling hopeless, restless or fidgety, and thoughts about suicide). Participants are also able to report during the post-test their satisfaction with the intervention and suggestions for improving the intervention.

## Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Mississippi Department of Mental Health has a central data repository that is supposed to be updated monthly with previous month's service level and substance use level data per client. There is a unique state identifier given to the individual in which we serve. This identifier stays with the client throughout their time spent at facilities.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Data includes client demographics, admissions, discharge, services provided, substance use, and individual development disabilities data.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Mississippi Department of Mental Health has the repository for data submission but does not collect all of the data from the State Programs, Community Mental Health Centers and Private Providers due to recent implementations and ongoing implementations of electronic health records systems.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

The 12 State Programs, Community Mental Health Centers and the Private Providers need additional funding to complete their implementations and design an electronic interface to the central data repository. They also need additional staffing to support and maintain the technology.

**Program Integrity - Required**

As part of our program integrity, we are requesting assistance from SAMHSA regarding data collected and submitted to SAMHSA through reports. During our federal site visit and on other occasions, we have been asked to provide data to SAMHSA that is outside the realm of the data submitted to TEDS. In particular, bed capacity, numbers of a specific population that are currently in treatment, and other specific reports on an “as needed” basis. We believe incomplete data collection and reporting is costing our state through block grant funds as well as competitive grant funds. We have begun a partnership with Mississippi State University NSPARC to develop a data collection and reporting system. We would like to request TA as we move toward procurement of a data system that will meet the needs of the Bureau of Alcohol and Drug Services and our sub-grantees. Specifically, we would like to converse with other agencies that have a productive state-wide data system.

# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1  
**Priority Area:** Responding to the Opioid Crisis  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV, TB

**Goal of the priority area:**

Implement or expand clinically appropriate evidence-based treatment service options and availability.

**Objective:**

Increase the number of opioid treatment programs that offer evidence-based, FDA-approved MAT.

**Strategies to attain the objective:**

Implement and expand access to and utilization of evidence-based, FDA-approved medication assisted treatment (MAT), in combination with psychosocial interventions.  
 Identify and treat opioid abuse during pregnancy.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Implement or expand clinically appropriate evidence-based treatment service options and availability.  
**Baseline Measurement:** 4 certified OTP's in the state.  
**First-year target/outcome measurement:** 2 additional providers will be certified in the state.  
**Second-year target/outcome measurement:** 2 additional providers will be certified in the state.

**Data Source:**

Certification database.

**Description of Data:**

The Certification database contains all certified providers and thier certifications.

**Data issues/caveats that affect outcome measures::**

**Indicator #:** 2  
**Indicator:** Identify and treat opioid abuse during pregnancy.  
**Baseline Measurement:** No planning meetings.  
**First-year target/outcome measurement:** Conduct at least 2 planning meetings between Medicaid and DMH-BADS on developing a voucher system for pregnant women in treatment.  
**Second-year target/outcome measurement:** Implement a voucher system for pregnant women supporting MAT and psychosocial treatment access for pregnant females.

**Data Source:**

Meeting agendas and sign-in sheets.

**Description of Data:**

Agendas stating the scope of planning and work to be accomplished.

**Data issues/caveats that affect outcome measures::**

**Priority #:** 2  
**Priority Area:** Pregnant Women and Women with Dependent Children  
**Priority Type:** SAT  
**Population(s):** PWWDC, TB

**Goal of the priority area:**

To ensure the delivery of quality specialized services to pregnant women and women with dependent children.

**Objective:**

Educate obstetrician, pediatric and family medicine providers to recognize and appropriately treat and refer women of child-bearing age with OUDs. Educate the substance abuse disorders workforce on treatment of pregnant women, to include MAT.

**Strategies to attain the objective:**

Strategies to Obtain the Goal: The Department of Mental Health's (DMH) Bureau of Alcohol and Drug Services (BADs) will continue to certify and provide funding to support fourteen (14) community-based primary residential treatment programs for adult females and males. While all of the programs serve pregnant women, there are two specialized programs that are equipped to provide services for the duration of the pregnancy. Six (6) free-standing programs are certified by the DMH, making available a total of twenty (20) primary residential substance abuse treatment programs located throughout the 14 community mental health regions.

In addition to the substance use disorder treatment, these specialized primary residential programs will provide the following services: 1) primary medical care including prenatal care and childcare; 2) primary pediatric care for their children including immunization; 3) gender specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, parenting, and child care while the women are receiving these services; 4) therapeutic interventions for children in custody of women in treatment which may, among other things address their developmental needs and issues of sexual and physical abuse and neglect; 5) sufficient case management and transportation services to ensure that women and their children have access to the services provided in (1) through (4).

The DMH Operational Standards require that all substance abuse programs must document and follow written policies and procedures that ensure:

- Pregnant women are given priority for admission;
- Pregnant women may not be placed on a waiting list. Pregnant women must be admitted into a substance abuse treatment program within forty-eight (48) hours;
- If a program is unable to admit a pregnant woman due to being at capacity; the program must assess, refer, and place the individual in another certified DMH certified program within 48 hours;
- If a program is unable to admit a pregnant woman, the woman must be referred to a local health provider for prenatal care until an appropriate placement is made;
- If a program is at capacity and a referral must be made, the pregnant woman must be offered an immediate face to face assessment at the agency or another DMH certified provider. If offered at another DMH certified program, the referring program must facilitate the appointment at the alternate DMH certified program. The referring provider must follow up with the certified provider and program to ensure the individual was placed within forty-eight (48) hours.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** The percentage of women served who successfully completed treatment.  
**Baseline Measurement:**  
**First-year target/outcome measurement:** Increase by 2.5% the number of pregnant women who successfully complete treatment during 2017-2018.  
**Second-year target/outcome measurement:** Increase by 2.5% the number of pregnant women who successfully complete treatment during 2018-2019.  
**Data Source:**

Annual Monitoring visits, Central Data Repository, and Programs will provide policy and procedures ensuring priority is given to pregnant women.

**Description of Data:**

BADS will conduct monitoring visits annually to ensure programs are giving priority to pregnant women. Treatment episode data sets will be used to determine the number of pregnant women who successfully complete treatment each year.

**Data issues/caveats that affect outcome measures::**

Funding issues could affect the availability of services.

**Indicator #:** 2

**Indicator:** The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete treatment.

**Baseline Measurement:**

**First-year target/outcome measurement:** Increase by 25% the number of pregnant women that have access to MAT during FY 2017-2018

**Second-year target/outcome measurement:** Increase by 25% the number of pregnant women that have access to MAT during FY 2018-2019

**Data Source:**

Annual monitoring visits.

**Description of Data:**

BADS will conduct monitoring visits annually to ensure programs are giving priority to pregnant women. Treatment episode data sets will be used to determine the number of pregnant women who utilized MAT during treatment and successfully complete treatment each year.

**Data issues/caveats that affect outcome measures::**

The majority of MAT clinics only accept cash, which may cause a significant hardship. Funding issues could affect the availability of services; however, MS DMH has sought and received funding through the 21st Century Cures grant in an effort to increase the number of certified MAT facilities and defer costs for pregnant women. Finding physicians who have adapted to the medical practice of MAT. Finding physicians who are knowledgeable of how to appropriately code/bill Medicaid for MAT.

**Priority #:** 3  
**Priority Area:** IV Drug Users  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV, TB

**Goal of the priority area:**

The proportion of IV Drug Users who were admitted into treatment and who successfully completed treatment.

**Objective:**

Continue delivering specialized treatment services to injecting drug users throughout the state.

**Strategies to attain the objective:**

- All DMH certified substance abuse programs must document and follow written policies and procedures that ensure:
- A. Individuals who use IV drugs are provided priority admission over non-IV drug users.
  - B. Individuals who use IV drugs are placed in the treatment program identified as the best modality by the assessment within forty-eight (48) hours.
  - C. If a program is unable to admit an individual who uses IV drugs due to being at capacity, the program must assess, refer and place the individual in another certified DMH program within forty-eight (48) hours.
  - D. If unable to complete the entire process as outlined in sectioned C., DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place an individual who uses IV drugs cannot exceed forty-eight (48) hours from the initial request for treatment from the individual.
  - E. If a program is at capacity and a referral must be made, the referring provider is responsible for assuring the establishment of alternate placement at

another certified DMH program within forty-eight (48) hours.

F. The referring provider is responsible for ensuring the individual was placed within forty-eight (48) hours.

G. In the case there is an IV drug user that is unable to be admitted because of insufficient capacity, the following interim services will be provided:

1. Counseling and education regarding HIV, Hepatitis, and TB, the risks of sharing needles, the risk of transmission to sex partners and infants, and the steps to prevent HIV transmission; and
2. Referrals for HIV, Hepatitis, and TB services made when necessary.

### Annual Performance Indicators to measure goal success

<b>Indicator #:</b>	1
<b>Indicator:</b>	The percentage of IV drug users successfully completed treatment.
<b>Baseline Measurement:</b>	393 IV drug users complete treatment
<b>First-year target/outcome measurement:</b>	Increase by 1% the number of IV Drug Users who successfully complete treatment after admission.
<b>Second-year target/outcome measurement:</b>	Increase by 2% the number of IV Drug Users who successfully complete treatment after admission.

**Data Source:**

Annual Monitoring visits. Programs will provide policy and procedures ensuring priority is given to IV drug users.

**Description of Data:**

BADS will conduct monitoring visits annually to ensure programs are giving priority to IV drug users. Treatment episode data sets will be used to determine the number of IV drug users who successfully complete treatment each year.

**Data issues/caveats that affect outcome measures::**

None foreseen

**Priority #:** 4  
**Priority Area:** HIV  
**Priority Type:** SAT  
**Population(s):** EIS/HIV

**Goal of the priority area:**

To increase the number of individuals in all substance use disorder treatment services to know their HIV status, modes of transmission, preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases, tuberculosis and hepatitis.

**Objective:**

1. Fervently encourage HIV testing
2. Explicitly explain the benefits of HIV testing
3. Provide education pertaining to modes of transmission, preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases, tuberculosis and hepatitis
4. Offer HIV testing immediately after fervently encouraging HIV testing, providing education and explicitly explaining the benefits of testing

**Strategies to attain the objective:**

Substance use disorder providers will fervently encourage HIV testing, explicitly explain the benefits, provide education and immediately after, offer testing.

### Annual Performance Indicators to measure goal success

<b>Indicator #:</b>	1
<b>Indicator:</b>	Individuals receiving substance use disorder services will know their HIV status and become aware and/or increase awareness of the severity of HIV/AIDS, tuberculosis, sexually transmitted diseases and hepatitis.
<b>Baseline Measurement:</b>	Currently there is no baseline, because that data is not being collected at this time.

**First-year target/outcome measurement:** Sixty percent (60%) of individuals in all substance use disorder treatment services will know their HIV status, modes of transmission, preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases, tuberculosis and hepatitis.

**Second-year target/outcome measurement:** Seventy percent (70%) of individuals in all substance use disorder treatment services will know their HIV status, modes of transmission, preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases, tuberculosis and hepatitis.

**Data Source:**

An HIV Early Intervention Services Reporting Form

**Description of Data:**

An HIV Early Intervention Services Reporting Form will be completed by all substance use disorder providers each year to report data to the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Services

**Data issues/caveats that affect outcome measures::**

Individuals receiving substance use disorder services may opt out of taking an HIV test.

**Priority #:** 5  
**Priority Area:** STDs, Hepatitis, and Tuberculosis  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV, TB

**Goal of the priority area:**

The majority of MAT clinics only accept cash, which may cause a significant hardship. Funding issues could affect the availability of services. Finding physicians who have adapted to the medical practice of MAT. Finding physicians who are knowledgeable of how to appropriately code/bill Medicaid for MAT.

**Objective:**

The state will work with physicians and MAT providers to accept Medicaid, private insurance, and other payment options to make MAT more readily available to clients.

**Strategies to attain the objective:**

Education regarding funding in partnership with private insurance providers, Division of Medicaid and the Department of Mental Health, BADS.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Testing/Education for STD's, Hepatitis and Tuberculosis  
**Baseline Measurement:** 45% percent of primary residential programs currently offer on-site rapid testing for HIV and Hepatitis  
**First-year target/outcome measurement:** 50% of the primary residential programs will offer on-site rapid testing for HIV and Hepatitis during 2017-2018  
**Second-year target/outcome measurement:** 60% of the primary residential programs will offer on-site rapid testing for HIV and Hepatitis during 2018-2019

**Data Source:**

Monitoring visits and Annual SABG progress report

**Description of Data:**

BADS will conduct monitoring visits to ensure the completion of this goal. During these monitoring visits individual's records at the 14 community mental health centers will be monitored routinely for documentation of these activities on the DMH Educational/Assessment Forms. Programs will also annual submit a SABG progress report to Mississippi Department of Mental health reporting progress on

each of the block grant goals.

**Data issues/caveats that affect outcome measures::**

Training time needed for HIV and Hepatitis rapid testing and the cost could pose an issue for this goal.

**Priority #:** 6  
**Priority Area:** Recovery Support  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV, TB

**Goal of the priority area:**

To decrease recidivism in Mississippi.

**Objective:**

Clients will be connected with appropriate recovery support services on discharge.

**Strategies to attain the objective:**

Recovery support plans will become part of the client record.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Increase the number of recovery support specialists by 3%.  
**Baseline Measurement:** Currently there are 60 certified recovery support specialists in the state for SUD.  
**First-year target/outcome measurement:** Increase the number of recovery support specialists by 3%.  
**Second-year target/outcome measurement:** Increase the number of recovery specialists by 3%.

**Data Source:**

Workforce development training database.

**Description of Data:**

The workforce development division of DMH certifies recovery support specialists for the agency.

**Data issues/caveats that affect outcome measures::**

**Priority #:** 7  
**Priority Area:** Trauma  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV

**Goal of the priority area:**

The proportion of SUD workforce workers trained on Trauma throughout the state every year

**Objective:**

Provide education and intervention techniques to SUD providers that serve victims of trauma

**Strategies to attain the objective:**

The Mississippi Department of Mental Health, Bureau of Community Services and the Bureau of Alcohol and Drug Services are working collaboratively to provide training intended to address the effects of trauma. These trainings will be particularly helpful for adult and child survivors of abuse, disaster, crime, shelter populations, and others. It will be aimed at promoting relationships rather than focusing on the traumatic events in their lives.

The trainings can also be utilized by first providers, frontline service providers and agency staff.

### Annual Performance Indicators to measure goal success

**Indicator #:** 1  
**Indicator:** Infuse trauma assessments within the clinical assessment phase of intake.  
**Baseline Measurement:** Implementation will begin by January 1, 2018.  
**First-year target/outcome measurement:** At least 25 individuals utilize the functional assessment.  
**Second-year target/outcome measurement:** At least 25 additional individuals will utilize the functional assessment.

**Data Source:**

Training logs for functional assessment trainings..

**Description of Data:**

Number of trainings, sign-in sheets, agendas

**Data issues/caveats that affect outcome measures::**

**Priority #:** 8  
**Priority Area:** Co-occurring Disorders  
**Priority Type:** SAT  
**Population(s):** PWWDC, PWID, EIS/HIV, TB

**Goal of the priority area:**

Broaden the knowledge base of the Community Mental Health Centers (CMHCs) to their specific co-occurring conditions and capacities.

**Objective:**

Assess the co-occurring conditions of all fourteen (14) CMHCs to determine whether they are Co-Occurring Capable and Co-Occurring Enhanced.

**Strategies to attain the objective:**

In an attempt to improve the co-occurring disorders (mental health, MH, and substance use disorder, SUD) treatment services in Mississippi, the Bureau of Alcohol Drug Services (BADs) have developed the Co-Occurring Capabilities of Mississippi project. The BADs have come to the realization that before changes can be made to its current treatment structure, an accurate and multi-dimensional picture of services offered, statewide, is fundamental. In fiscal year 2017-2018, the BADs plans to conduct a thorough assessment of the CMHCs and have selected the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) assessment tool to obtain objective information on the co-occurring conditions of the providers with whom it contracts with for MH and SUD treatment services. The DDCMHT assessment tool will allow the BADs to properly categorize each treatment program into one (1) of two (2) primary categories based off the agency's existing co-occurring conditions: Co-Occurring Capable (COC) or Co-Occurring Enhanced (COE).

### Annual Performance Indicators to measure goal success

**Indicator #:** 1  
**Indicator:** Determine the co-occurring level of the Community Mental Health Centers (CMHCs) by way of a DDCMHT assessment. (Co-occurring Level will either be Co-Occurring Capable or Co-Occurring Enhanced).  
**Baseline Measurement:** In grant year 2017-2018, 0% of the CMHCs Co-Occurring Conditions was identified.  
**First-year target/outcome measurement:** Increase the number of CMHCs to be assessed (DDCMHT) to 50% by the end of grant year 2018.  
**Second-year target/outcome measurement:** Increase by an additional 50% by the end of grant year 2019.

**Data Source:**

DDCMHT Scoring Results

**Description of Data:**

DDCMHT Scoring Results

**Data issues/caveats that affect outcome measures::**

Obtaining the by-in from the CMHCs during the assessment process.  
Willingness of the provider to embrace the changes needed as a result of the DDCMHT assessment.

**Priority #:** 9  
**Priority Area:** Prescription Drug Use  
**Priority Type:** SAP  
**Population(s):** PP, Other (Adolescents w/SA and/or MH, Students in College, )

**Goal of the priority area:**

To reduce the number of prescriptions and dosage units.

**Objective:**

To reduce the number of opioids being prescribed by healthcare professionals.

**Strategies to attain the objective:**

Provide education through media campaigns, town hall meetings, and healthcare policy and practice changes.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Adolescent Past 30 Day Prescription Drug Use  
**Baseline Measurement:** 3.4% of 6-11th graders report using prescription drugs that were not prescribed to them by a doctor in the past 30 days (2016)  
**First-year target/outcome measurement:** Reduce the baseline prevalence estimate by .5% in year one  
**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate by 1% in year two

**Data Source:**

Smarrtrack

**Description of Data:**

Smarrtrack Description: The MS Department of Mental Health (DMH), Bureau of Alcohol and Drug Services began collaborating with the MS Department of Education, Office of Healthy Schools in 2001 to implement a statewide youth survey (SmartTrack) that measures youth consumption and consequence patterns of alcohol and drug use in MS. It also measures other risk and protective factors including drug-related disapproval attitudes and perceived risk of harm, suicide ideation and attempts, health, nutrition, family influences, school safety and bullying, and social engagement.

**Data issues/caveats that affect outcome measures::**

We are currently investigating new forms of data collection. We will request technical assistance in this area.

**Indicator #:** 2  
**Indicator:** Perception of Harm  
**Baseline Measurement:** In 2016, 3.4% of Mississippi youth in grades 6-11 reported having used prescription drugs in a way other than how they were prescribed.  
**First-year target/outcome measurement:** Reduce the baseline prevalence estimate of youth in grades 6-11 that report having used prescription drugs in a way other than how they were prescribed by .5% during the first year  
**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate of youth in grades 6-11 that report having used

prescription drugs in a way other than how they were prescribed by 1% during the second year

**Data Source:**

SmartTrack

**Description of Data:**

Smarttrack Description: The MS Department of Mental Health (DMH), Bureau of Alcohol and Drug Services began collaborating with the MS Department of Education, Office of Healthy Schools in 2001 to implement a statewide youth survey (SmartTrack) that measures youth consumption and consequence patterns of alcohol and drug use in MS. It also measures other risk and protective factors including drug-related disapproval attitudes and perceived risk of harm, suicide ideation and attempts, health, nutrition, family influences, school safety and bullying, and social engagement.

**Data issues/caveats that affect outcome measures::**

None foreseen

**Priority #:** 10

**Priority Area:** Alcohol Use

**Priority Type:** SAP

**Population(s):** PP, Other (Adolescents w/SA and/or MH, Students in College, )

**Goal of the priority area:**

Goal: Reduce alcohol use and substance abuse to protect the health, safety, and quality of life for Mississippi adolescents and young adults

**Objective:**

Reduce past 30 day use and binge drinking among 12-25 year olds.

**Strategies to attain the objective:**

Strategy:

BADS prevention programs will provide information to communities about the increased risk associated with early exposure to alcohol and its potential negative consequences.

BADS prevention programs will work with local community coalitions to implement local policies that will lower alcohol consumption among youth.

BADS prevention programs will continue to implement evidence-based practices, programs, and strategies aimed at reducing underage drinking and alcohol abuse.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Adolescent Past Month Alcohol Use

**Baseline Measurement:** 8.8% (21,000) of youth ages 12-17 reported Alcohol Use during the Past Month, 2014-2015 NSDUHs

**First-year target/outcome measurement:** Reduce the baseline prevalence estimate by .5% in year one

**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate by 1% in year two

**Data Source:**

NSDUH

**Description of Data:**

Smarttrack Description: The MS Department of Mental Health (DMH), Bureau of Alcohol and Drug Services began collaborating with the MS Department of Education, Office of Healthy Schools in 2001 to implement a statewide youth survey (SmartTrack) that measures youth

consumption and consequence patterns of alcohol and drug use in MS. It also measures other risk and protective factors including drug-related disapproval attitudes and perceived risk of harm, suicide ideation and attempts, health, nutrition, family influences, school safety and bullying, and social engagement.

NSDUH Description: The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

**Data issues/caveats that affect outcome measures::**

None foreseen

**Indicator #:** 2

**Indicator:** Young Adult Past Month Alcohol Use

**Baseline Measurement:** 46.9% (158,000) of young adults ages 18-25 reported alcohol use in the Past Month, 2014-2015 NSDUHs

**First-year target/outcome measurement:** Reduce the baseline prevalence estimate by .5% in year two

**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate by 1% in year two

**Data Source:**

NSDUH

**Description of Data:**

NSDUH Description: The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

**Data issues/caveats that affect outcome measures::**

None

**Priority #:** 11

**Priority Area:** Marijuana Use

**Priority Type:** SAP

**Population(s):** PP, Other (Adolescents w/SA and/or MH, Students in College, )

**Goal of the priority area:**

Goal: Reduce marijuana use to protect the health, safety, and quality of life for Mississippi adolescents

**Objective:**

Reduce past 30 days use among 12-17 year olds

**Strategies to attain the objective:**

Strategy:

BADS will continue to raise population level change on social norms pertaining to marijuana use among youth.

BADS will continue to raise and increase awareness of the developmental risk associated with early exposure to marijuana use and its potential immediate and long-term side effects.

BADS will continue to educate the general public across divers social groups (gender, race-ethnicity, educational levels, and sub-state regions) on the dangers of marijuana use through evidence based strategies.

## Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Adolescent Past Month Marijuana Use

**Baseline Measurement:** 5.3% (13,000) of youth ages 12-17 reported marijuana use in the Past Month, 2014-2015 NSDUHs

**First-year target/outcome measurement:** Reduce the baseline prevalence estimate by .5% in year one

**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate by 1% in year two

**Data Source:**

NSDUH

**Description of Data:**

NSDUH Description: The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

**Data issues/caveats that affect outcome measures::**

None Foreseen

---

**Indicator #:** 2

**Indicator:** Young Adult Past Month Marijuana Use

**Baseline Measurement:** 13.9% (47,000) of young adults ages 18-25 reported Marijuana Use in the Past Month, 2014-2015 NSDUHs

**First-year target/outcome measurement:** Reduce the baseline prevalence estimate by .5% in year one

**Second-year target/outcome measurement:** Reduce the baseline prevalence estimate by 1% in year two

**Data Source:**

NSDUH

**Description of Data:**

NSDUH Description: The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

**Data issues/caveats that affect outcome measures::**

None expected

**Footnotes:**

## Planning Tables

**Table 2 State Agency Planned Expenditures**

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017      Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$9,675,618		\$0	\$2,562,399	\$6,858,831	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$1,811,492		\$0	\$0	\$0	\$0	\$0
b. All Other	\$7,864,126		\$0	\$2,562,399	\$6,858,831	\$0	\$0
2. Primary Prevention	\$2,755,448		\$0	\$2,700,958	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. Early Intervention Services for HIV	\$688,862		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$657,313		\$0	\$2,562,399	\$6,858,831	\$0	\$0
<b>11. SABG Total (Row 1, 2, 3, 4 and 10)</b>	<b>\$13,777,241</b>	<b>\$0</b>	<b>\$0</b>	<b>\$7,825,756</b>	<b>\$13,717,662</b>	<b>\$0</b>	<b>\$0</b>

\* Prevention other than primary prevention

\*\* The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

**Footnotes:**

DMH financial system only allows DMH to have information on DMH related expenditures: both state and federal funds we receive (these funds were added). We are currently investigating two different data systems that will have the mechanism to allow state agencies to share financial and programmatic data. The agencies that will be sharing data with each other include: Medicaid, Department of Health, MS

Bureau of Narcotics and the MS Board of Pharmacy. Our target date for this has been pushed to early 2019 due to agency budgets and bidding for the data system.

# Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	6000	150
Women with Dependent Children	22000	0
Individuals with a co-occurring M/SUD	74000	356
Persons who inject drugs	5000	1269
Persons experiencing homelessness	14000	433

**Please provide an explanation for any data cells for which the stats does not have a data source.**

Women with Dependent Children is not collected in our CDR (Central Data Repository) because it is not a required field in TEDS. The Bureau of Alcohol and Drug Services believes the CDR data is under reported. BADS is presently investigating new data systems to more accurately collect our data. BADS requesting technical assistance from SAMHSA in this area.

**Footnotes:**

# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2017      Planning Period End Date: 9/30/2019

Expenditure Category	FY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$9,675,618
2 . Primary Substance Abuse Prevention	\$2,755,448
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV *	\$688,862
5 . Administration (SSA Level Only)	\$657,313
<b>6. Total</b>	<b>\$13,777,241</b>

\* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

**Footnotes:**

# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2017    Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	\$637,455
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$637,455</b>
Education	Universal	\$1,119,301
	Selective	\$63,569
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$1,182,870</b>
Alternatives	Universal	\$261,160
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$261,160</b>
Problem Identification and Referral	Universal	
	Selective	
	Indicated	\$148,833
	Unspecified	
	<b>Total</b>	<b>\$148,833</b>

Community-Based Process	Universal	\$297,666
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$297,666</b>
Environmental	Universal	\$152,672
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$152,672</b>
Section 1926 Tobacco	Universal	\$74,792
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$74,792</b>
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
<b>Total Prevention Expenditures</b>		<b>\$2,755,448</b>
<b>Total SABG Award*</b>		<b>\$13,777,241</b>
<b>Planned Primary Prevention Percentage</b>		<b>20.00 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

## Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2017      Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	\$1,194,093
Universal Indirect	\$1,348,953
Selective	\$63,569
Indicated	\$148,833
<b>Column Total</b>	<b>\$2,755,448</b>
<b>Total SABG Award*</b>	<b>\$13,777,241</b>
<b>Planned Primary Prevention Percentage</b>	<b>20.00 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

# Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

Planning Period Start Date: 10/1/2017    Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	<input type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBT	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

**Footnotes:**

# Planning Tables

**Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities**

Planning Period Start Date: 10/1/2017      Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems		\$100,000		
2. Infrastructure Support		\$50,000		
3. Partnerships, community outreach, and needs assessment				
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement				
6. Research and Evaluation				
7. Training and Education				
<b>8. Total</b>	<b>\$0</b>	<b>\$150,000</b>	<b>\$0</b>	<b>\$0</b>

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**

The Bureau of Alcohol and Drug Services believes the CDR data is under reported. BADS is presently investigating new data systems to more accurately collect our data. BADS requesting technical assistance from SAMHSA in this area.

# Environmental Factors and Plan

## 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

### Narrative Question

---

#### 1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>25</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>26</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>27</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>28</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>29</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>30</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>31</sup> SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>32</sup> The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>33</sup> Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>34</sup> and ACOs<sup>35</sup> may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>36</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>37</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>38</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>39</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>40</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>41</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>42</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>43</sup> SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>44</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>25</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:1027-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 527-77

<sup>26</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>27</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>28</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

<sup>29</sup> <http://www.samhsa.gov/health-disparities/strategic-initiatives>

<sup>30</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>31</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, [http://www.nami.org/Content/NavigationMenu/State\\_Advocacy/About\\_the\\_Issue/Integration\\_MH\\_And\\_Primary\\_Care\\_2011.pdf](http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf); Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>32</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- <sup>33</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- <sup>34</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- <sup>35</sup> New financing models, [http://www.samhsa.gov/co-occurring/topics/primary-care/financing\\_final.aspx](http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx)
- <sup>36</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- <sup>37</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- <sup>38</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- <sup>39</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- <sup>40</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. *Health Affairs*. 2014; 33(4): 700-707
- <sup>41</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, *JAMA Psychiatry*. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, *JAMA Psychiatry*. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. *JAMA Psychiatry*. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. *Annals of Emergency Medicine*. 2011; 58(2): 218
- <sup>42</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- <sup>43</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- <sup>44</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

**Please respond to the following items in order to provide a description of the healthcare system and integration activities:**

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The DMH envisions a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports. The DMH is committed to maintaining a statewide comprehensive system of prevention, treatment and rehabilitation which promotes quality care, cost effective services, and ensures the health and welfare of individuals. Presently, integrated mental health, substance use and primary health care services are not all available at the same location on a statewide basis. However, in 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care. IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc. Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care. Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association. Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue. In 2011, 2012, and 2015, DMH submitted grant applications to SAMHSA and CMH to develop initiatives to integrate mental health and primary healthcare. Although none of these grant applications were successful, the opportunities for collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-

occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Collaborative activities involving mental health and/or substance use, primary health, and other support service providers include:

A representative from the Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State-Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) Teams across the state.

As part of their application to the DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services.

The DMH Division of Recovery and Resiliency is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across Bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Providers.

The DMH Division of Alzheimer's Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.

The DMH Bureau of Alcohol and Drug Services continues to work with the Attorney General's Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner.

The DMH Bureau of Alcohol and Drug Services partners with the MS Department of Rehabilitation Services to fund substance use treatment services to individuals in transitional residential programs.

The DMH Bureau of Alcohol and Drug Services works collaboratively with the MS Band of Choctaw Indians and continue to fund prevention services with Choctaw Behavioral Health.

The DMH Bureau of Alcohol and Drug Service has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. Through this partnership, trainings are provided around the state. The training is also available for A&D personnel located at community mental health centers.

The DMH Bureau of Community Services' Annual Provider Survey gathers self-reported information on integrated primary and behavioral health care, as well as on tele-medicine opportunities.

In December 2014, the DMH Bureau of Community Services and the DMH Bureau of Outreach, Planning and Development applied for and were awarded membership in the SAMHSA-HRSA Center for Integrated Health Solutions' (CIHS) Innovation Community entitled Building Integrated Behavioral Health in a Primary Care Setting. This collaboration is between the DMH, a local CMHC, and a local FQHC.

In March 2015, the DMH Division of Recovery and Resiliency applied for and was awarded a 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Subcontract for the Expansion of Policy Academy Action Plans.

In October 2016, the Department of Mental Health partnered with the Department of Health and the Mississippi Public Health Institute for a State Forum on Integrated Care. One of the outcomes of the forum was to develop a document to help guide integrated care in Mississippi as we move forward. The Roadmap for Integrated Care in Mississippi has been completed and is now available. Forum participants developed practical strategies for innovative health system transformation as detailed in the action plan in Section III of the document. These components will serve as the foundation for the Roadmap to Integrated Care in Mississippi. DMH's Integration Work Group served as the advisory committee for the State Forum event.

DMH's Integration Work Group is a multidisciplinary, interagency work group which was created in August 2011 for the purpose of developing strategies and partnerships to facilitate the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care to create a holistic approach to care.

In addition, the DMH has funded the development of eight PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists).

Health information is obtained for all individuals seeking services from the DMH certified providers on the Initial Assessment. A medical examination is required for individuals in supervised and residential programs, as well as in senior psychosocial programs. Also, Certified Peer Support Specialists are trained to assist individuals receiving services in accessing all health care services.

Four Community Mental Health Centers report working directly with their local Community Health Center to provide primary care and other medical services; two of those Community Mental Health Centers have a formal agreement with the Community Health Center. One Community Mental Health Center reports that they provide primary health care services at the CMHC. LIFECORE Health Group/ Region 3 Mental Health Center located in Tupelo, Mississippi, serves seven counties and is a comprehensive health system. The main center in Tupelo is a ten thousand square foot building devoted to the co-location and integration of primary health care and behavioral health care services. Included in this facility is a pharmacy which provides both medical and psychotropic medication for all its clients. Additionally, Region 3 operates a mobile primary care unit which travels to four counties in its region.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  Yes  No

and Medicaid?  Yes  No

4. Who is responsible for monitoring access to M/SUD services by the QHP?  
The Department of Health

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  Yes  No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education  Yes  No

b) Health risks such as

i) heart disease  Yes  No

ii) hypertension  Yes  No

viii) high cholesterol  Yes  No

ix) diabetes  Yes  No

c) Recovery supports  Yes  No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  Yes  No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  Yes  No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

On April 17-18, 2017, two staff from the Mississippi Department of Mental Health participated in the Parity Academy for Commercial Insurance at SAMHSA. In Mississippi, the list of issues and problems are extensive on the Commercial side. The Division of Medicaid in Mississippi does not currently reimburse for substance use services.

10. Does the state have any activities related to this section that you would like to highlight?

All DMH certified providers are required to complete Initial Assessments for individuals seeking services. This assessment is used to document pertinent information that is used as part of the process for determining what service or combination of services might best meet an individual's stated/presenting need(s). Individuals seeking services are asked questions regarding medical history, developmental history for children and youth, family history of medical conditions, and current chronic medical conditions or diseases such as sleep and appetite issues, hypertension, diabetes, thyroid or other medical conditions. DMH certified providers are required to make referrals to appropriate services or other mental health or medical services providers based on the information obtained during the Initial Assessment.

Please indicate areas of technical assistance needed related to this section

**Footnotes:**

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

---

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>45</sup>, [Healthy People, 2020](#)<sup>46</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>47</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)<sup>48</sup>.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>49</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>50</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>51</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

---

<sup>45</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>46</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>47</sup> <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

<sup>48</sup> <http://www.thinkculturalhealth.hhs.gov>

<sup>49</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>50</sup> <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

**Please respond to the following items:**

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
  - a) Race  Yes  No
  - b) Ethnicity  Yes  No
  - c) Gender  Yes  No
  - d) Sexual orientation  Yes  No
  - e) Gender identity  Yes  No
  - f) Age  Yes  No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?  Yes  No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  Yes  No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?  Yes  No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?  Yes  No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?  Yes  No

7. Does the state have any activities related to this section that you would like to highlight?

The Cultural Competency Plan Implementation Workgroup recommended inclusion of language and proficiency in the DMH data collection standards including questions regarding primary language spoken by the individual, language preferred by the individual, language written by the individual, and whether or not the individual receiving services needed an interpreter. Due to funding constraints, the Workgroup was informed that additional questions to the current data collection system are currently not possible. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible. When cultural competency trainings are conducted in the state, the Cultural and Linguistic Competency Training Evaluation form includes a sexual orientation question. The data from the form is placed in a comprehensive report for the training results. The current DMH Central Data Repository does not address or track language needs. Language needs are addressed by creating a comprehensive list of translators and interpreters in Mississippi as well as a list of resources for alternate forms of communication for individuals with hearing, visual and/ or other disabilities. These two lists have been mailed to programs to assist with providing language needs. The state has a State Plan for Cultural Competency, which includes workforce-training. The state provides trainings on cultural competence, CLAS standards, and cultural diversity to DMH certified providers. The state plans to provide a web-based CLAS Standards training in the future.

Please indicate areas of technical assistance needed related to this section

**Footnotes:**

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

---

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>52</sup>, The New Freedom Commission on Mental Health<sup>53</sup>, the IOM<sup>54</sup>, and the NQF<sup>55</sup>. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>56</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))<sup>57</sup> are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))<sup>58</sup> was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

---

<sup>52</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>53</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>54</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>55</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>56</sup> <http://psychiatryonline.org/>

<sup>57</sup> <http://store.samhsa.gov>

<sup>58</sup> <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

---

**Please respond to the following items:**

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
  
2. Which value based purchasing strategies do you use in your state (check all that apply):
  - a)  Leadership support, including investment of human and financial resources.
  - b)  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)  Use of financial and non-financial incentives for providers or consumers.
  - d)  Provider involvement in planning value-based purchasing.
  - e)  Use of accurate and reliable measures of quality in payment arrangements.
  - f)  Quality measures focus on consumer outcomes rather than care processes.
  - g)  Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h)  The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

In the recent years the state has become much more intentional in understanding of emerging or promising practices. There is not a defined evaluation process to assess emerging and promising practices at this time. The Bureau of Alcohol and Drug Services is requesting technical assistance for this section.

We have been working with the Division of Medicaid to have substance abuse approved as a billed service for medicaid. We have recently met that goal. We would be interested in discussing how other states are receiving funds from Medicaid, whether through direct Medicaid funding or through a service file exchange.

**Footnotes:**

# Environmental Factors and Plan

## 6. Self-Direction - Requested

### Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

### Please respond to the following items:

1. Does your state have policies related to self-direction?  Yes  No
2. Are there any concretely planned initiatives in our state specific to self-direction?  Yes  No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

The Bureau of Alcohol and Drug Services is planning to transition to a "fee for services" budgeting system in FY 2018-2019.

Does the state have any activities related to this section that you would like to highlight?

Mississippi has adopted the 10 Components of Recovery and SAMHSAs definition of recovery. Self-direction is one of the components that Mississippi has embraced. DMH staff provides training across the state on recovery and Recovery-Oriented Systems of Care.

At the current time, the Mississippi Department of Mental Health operates on a reimbursement payment system. Cash requests are submitted monthly by sub-grant recipients with specific items requested by category (salaries/fringe, contractual, commodities, equipment) for reimbursement. These requests are reviewed by grants management staff, accounts payable staff, and programmatic staff to insure items requested to be reimbursed are within the approved budget justification. The state accounting system prevents any service provider from being paid in excess of their budget award.

Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not meet the programmatic intention of the grant funds or do not

meet the "necessary and reasonable" test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise.

The Department of Mental Health has an Audit Division with two major functions:

- 1) Conduct annual compliance audits of grant sub-recipients. Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc. Audit procedures are outlined in the agencies "Central Office Audit Guide."
- 2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines, reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies "Service Providers Manual" that is available on-line on the Mississippi Department of Mental Health website.

*Please indicate areas of technical assistance needed to this section.*

**Footnotes:**

## Environmental Factors and Plan

### 7. Program Integrity - Required

#### Narrative Question

---

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

---

#### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight?

Specific grant requirements are conveyed to Department of Mental Health service providers during the RFP process. Additionally, service providers are required to sign a packet of applicable agreements including both a list of "Federal Assurances" and Mississippi Department of Mental Health Assurances on an annual basis. Any additional requirements specific to grant funding are included in this annual packet to be signed by the program administrator annually.

Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not meet the programmatic intention of the grant funds or do not meet the "necessary and reasonable" test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise.

The Mississippi Department of Mental Health operates on a reimbursement payment system. Cash requests are submitted monthly by sub-grant recipients with specific items requested by category (salaries/fringe, contractual, commodities, equipment) for reimbursement. These requests are reviewed by grants management staff, accounts payable staff, and programmatic staff to insure items requested to be reimbursed are within the approved budget justification. The state accounting system prevents any service provider from being paid in excess of their budget award.

The Department of Mental Health has an Audit Division with two major functions:

- 1) Conduct annual compliance audits of grant sub-recipients. Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc. Audit procedures are outlined in the agencies "Central Office Audit Guide."
- 2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines, reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies "Service Providers Manual" that is available on-line on the Mississippi Department of Mental Health website.

The Mississippi Department of Mental Health operates on a reimbursement payment system. Cash requests are submitted monthly by sub-grant recipients with specific items requested by category (salaries/fringe, contractual, commodities, equipment) for reimbursement. These requests are reviewed by grants management staff, accounts payable staff, and programmatic staff to insure items requested to be reimbursed are within the approved budget justification. The state accounting system prevents any service provider from being paid in excess of their budget award.

*Please indicate areas of technical assistance needed to this section*

The State of Mississippi is not requesting technical assistance in this area at this time.

**Footnotes:**

## Environmental Factors and Plan

### 8. Tribes - Requested

#### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>59</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>59</sup> <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

#### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?  
Quarterly during Advisory Counsel Meetings.
2. What specific concerns were raised during the consultation session(s) noted above?  
No, not at this time.  
Does the state have any activities related to this section that you would like to highlight?  
Involvement of Tribes

The Bureau of Alcohol and Drug Services (BADS) has a statewide Alcohol and Drug Services Advisory Council which meets quarterly. A member of the Council is the Director of Choctaw Behavioral Health, Choctaw Tribal Agency located in Philadelphia, MS. The Choctaw Tribal Agency works closely with BADS and administers two federal grants through the BADS office, prevention and workforce development. Datagadget, an internet substance abuse prevention database is utilized to gather specific information regarding Tribes. A representative from the Mississippi Band of Choctaw Indians currently serves on the Mississippi State Mental Health Planning and Advisory Council.

*Please indicate areas of technical assistance needed to this section*

No TA is being requested in this area.

#### Footnotes:

## Environmental Factors and Plan

### 9. Primary Prevention - Required SABG

#### Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

#### Please respond to the following items

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - Data on consequences of substance using behaviors
  - Substance-using behaviors
  - Intervening variables (including risk and protective factors)
  - Others (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - Children (under age 12)
  - Youth (ages 12-17)
  - Young adults/college age (ages 18-26)
  - Adults (ages 27-54)
  - Older adults (age 55 and above)
  - Cultural/ethnic minorities
  - Sexual/gender minorities
  - Rural communities
  - Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

Archival indicators (Please list)

YES

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Smarttrack

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?  Yes  No

If yes, (please explain)

n/a

If no, (please explain) how SABG funds are allocated:

Funds are allocated to communities based on historical funding. All SABG funding was scheduled to go to a fee-for-services beginning July 1, 2018, however, prevention has been placed on hold until July 1, 2019.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section

The state of Mississippi can benefit from technical assistance on transitioning prevention funding to a fee for service process, therefore moving away from historical funding amounts. In addition, any technical assistance that includes best practices for covering the 6 prevention strategies while doing this would be beneficial to our state.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  Yes  No

If yes, please describe

It is the Mississippi Association for Addiction Professionals (MAAP). The Certification Board governs the certification process for MAAP as a proud member of IC&RC (International Certification & Reciprocity Consortium). As such, the Board processes applications for initial certification and recertification. The Board is responsible for overseeing the maintenance of the Ethical Standards of Certified Professionals. The Certification Board consists of ten members--three of whom serve one-year terms; three of whom serve two-year terms; and three of whom serve three-year terms--along with a Chair or Co-Chairs, who are appointed by the President of MAAP. The President and President-Elect of MAAP serve as ex-officio members of the Certification Board.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  Yes  No

If yes, please describe mechanism used

A workforce development contract was awarded to a new sub-contractor. The sub-contractor is the Mississippi Public Health Institute. The Mississippi Public Health Institute focuses on the pressing health and health care issues facing communities. MSPHI is a nonprofit entity established in June, 2011, to protect and improve the health and well-being of Mississippians. They are committed to partnerships aimed at program innovation, health resources, education, applied research, and policy development. The Institute serves as a partner and convener to promote health, improve outcomes and encourage innovations in health systems. Staff have expertise in clinical health outcomes, medicine, health law, policy, public health, education, information technology, evaluation, social and behavioral health, and health systems

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No

If yes, please describe mechanism used

N/A

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section

Developing a formal mechanism to assess community readiness.

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No  
  
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan <http://www.dmh.ms.gov/pdf/FY13-17%20DMH%20Strategic%20Plan%20Final.pdf>
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b)  Timelines
  - c)  Roles and responsibilities
  - d)  Process indicators
  - e)  Outcome indicators
  - f)  Cultural competence component
  - g)  Sustainability component
  - h)  Other (please list):  
N/A
  - i)  Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No  
  
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based  
  
Yes, we have one but we have never use it to make decisions about strategies for block grant.  
  
Does the state have any activities related to this section that you would like to highlight?  
  
N/A

Please indicate areas of technical assistance needed related to this section.  
The functions of the Evidence Based Workgroup in regards to the block grant.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:
 

The Bureau of Alcohol and Drug services (BADs) currently funds four RADAR centers. Two are located in the Jackson metropolitan area (JSU and NCADD), one is in the southern portion of the state (DREAM of Hattiesburg), and one is in the northeastern portion of the state (Region 3 CMHC - Tupelo). All programs funded by DMH participate in speaking engagements. The audiences vary greatly from businesses to schools to social and community clubs and organizations. Several conferences are held annually that offer prevention tracks as a main part of the conference. Practically 100% of our programs participate in health fairs in their local communities. Initiatives of our prevention programs include but are not limited to Girl Power!, National Red Ribbon Week, Be Smart Week, National Smoke-Out Day, Poisons and Inhalants Prevention Week, and National Night Out. Several of our agencies maintain toll free numbers to serve as prevention information hot lines. The Mississippi Prevention Network (MPN) website [www.mpn.ms](http://www.mpn.ms) was established to connect substance abuse prevention professionals with valuable information, tools, and resources on alcohol, tobacco, and other drugs. The website is currently down, but will be revamped and regenerated in the near future. Non-prevention professionals also used this site to find information on alcohol, tobacco, and other drugs. This site was also used to communicate with other professionals in the field.

**b) Education:**

Prevention specialists continue to provide educational presentations on information appropriate for the particular topic and audience. Some examples of these presentations/programs include: Campus presentations, parenting classes, presentations regarding co-occurring issues with shared substance misuse risk factors, peer mediation programs, groups for families, educational groups, youth mini-conferences, and youth trends presentations. DREAM of Hattiesburg sponsors Senior and Junior Leadership programs. Each group involves 15 - 20 youth who conduct weekly meetings. These youth are involved in leadership development, mentoring, tutoring, and service-learning projects. A coalition was developed under the leadership of DREAM of Hattiesburg. The Southern Mississippi Coalition's goal is to reduce or prevent alcohol, tobacco, and other drugs abuse/use among youth in south Mississippi. Funded agencies continue to provide after school enrichment programs that include tutoring and computer assisted learning along with life skills training activities. Project Alert, Life Skills, All Stars, Parenting Adolescents Wisely, and The Incredible Years are some of the evidence-based programs implemented.

**c) Alternatives:**

Alternative activities that are being conducted by prevention specialists in the field includes the following events: Alcohol/Drug Studies Youth Camp, Teens on the Move, talent showcases, youth/adult leadership educational activities, summer day camps and a youth mini-conference.

**d) Problem Identification and Referral:**

Activities include a student assistance and employee assistance programs and peer counseling. BADS's Alcohol and Drug Treatment and Prevention Resource directories are utilized to make referrals whenever the need arises. Some of the programs described under the Education strategy could also fall under this category. A community mental health substance abuse counselor is available in each county and provides access to assessment and referral services through their treatment program.

**e) Community-Based Processes:**

The Bureau of Alcohol and Drug Services remains active to prevention interagency committees, task forces, advisory councils and other groups through their attendance at regularly scheduled meetings and participation in related activities. Funded programs are required as part of the Request for Proposal to establish a coalition with other DMH funded prevention programs in their respective catchment areas. Community involvement is instrumental for providing effective prevention services. Program staff are involved in numerous coalitions and tasks forces aimed at the reduction of substance/alcohol abuse within their communities. Some of the community partnerships subrecipient staff continue to be members of are: Southern Coalition Community Planning Coalition, Delta Law Enforcement Coalition, Ole Miss Task Force on Alcohol and Drugs, Rural Health Coalition Teen Talk Coalition, Long Beach Substance Abuse Task Force, Jackson County Children's Services Coalition, Region IX Prevention Coalition, Mississippi Underage Drinking Prevention Coalition of Hinds County, Mississippi Underage Drinking Prevention Coalition of Madison and Rankin Counties, Community Striving to Prevent Underage Drinking, Dream Community Planning Coalition, Gateway MAP Coalition, Gulf Coast Substance Abuse Task Force, Make A Promise Coalition for a Drug-Free Warren County, Metro Jackson Community Prevention Coalition, MADD Smarter Choices Community Coalition of Leake County, Smarter Choices Community Coalition of Lauderdale County, Sober Choices of Lee County Tunica County Coalition, Warren County Underage Drinking Coalition, and Mississippians Advocating Against Unhealthy Decisions.

**f) Environmental:**

BADS staff along with our various community partners, collaborate with and advise the Office of the Attorney General and the Department of Transportation to examine current legislation regarding underage drinking, driving under the influence, and tobacco access or use. Programs in each mental health region are required to conduct 40 merchant education trainings with individual merchants to provide information on the law regarding youth access to tobacco. BADS is currently working with multiple state agencies to educate the public on the misuse of prescription drugs and opioids, to change policies associated with prescribing, and to promote the use of the prescription drug monitoring program in our state to combat the emerging epidemic. Several of the funded providers are working on passing ordinances in their community to stop the sale of drug paraphenelia and hookah devices within convenience stores in there communities.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  Yes  No

If yes, please describe

We have a process in place, but because the programs are autonomous it is hard to grasp if all the prevention dollars are being used correctly, effectively, and efficiently. Over the last year, we implemented a practice requiring expenditures over \$500 dollars to obtain prior authorization from state office and extra justification that it's related to primary prevention.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

We really would like information on best practices for MS delivering prevention services and measuring the prevention dollars by strategies.

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan  
N/A

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a)  Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d)  Establishes a process for providing timely evaluation information to stakeholders
- e)  Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f)  Other (please list:)
- g)  Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a)  Numbers served
- b)  Implementation fidelity
- c)  Participant satisfaction
- d)  Number of evidence based programs/practices/policies implemented
- e)  Attendance
- f)  Demographic information
- g)  Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a)  30-day use of alcohol, tobacco, prescription drugs, etc
- b)  Heavy use
- Binge use

- Perception of harm
- c)**  Disapproval of use
- d)**  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)**  Other (please describe):

**Footnotes:**



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

**STRATEGIC PLAN  
FY 2013 - 2017**

**STAYING THE COURSE**

**July 1, 2012**

# Message from the Chair

---

Determining the best ways to make our Vision a reality is an ongoing effort. There are always going to be challenges, but as the Board of Mental Health's Strategic Planning Subcommittee presents the fourth Strategic Plan, the need for a Strategic Plan to guide our transformation to a community-based system is more important than ever. Looking ahead to the accomplishments we want to witness in the next five years helps keep our focus on change.

Each year's review of the Strategic Plan allows us to see the changes that are occurring. Progress has been made in each goal. While not all activities are complete, we are moving towards completion of objectives that will help fully develop a community-based system.

Furthermore, for the last several years, DMH has requested additional funds from the Legislature to address numerous activities listed in the Strategic Plan goals. While the State's budget has been such that no additional funds have been available, DMH will continue to request funds to help make the changes needed to provide more community supports.

Progress could not happen without the continuing commitment and efforts of all the Goal Leaders, Goal Team members, consumers, advocates and our community partners. The Strategic Planning Subcommittee sincerely appreciates everyone's contributions. We look forward to your continuing involvement as we stay the course on striving to reach our Vision.

*Margaret Cassada, M.D., Chair*  
Board 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  
Mrs. Rose Roberts, LCSW, 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

---

When the Mississippi Board of Mental Health and the Department of Mental Health set out to develop a Strategic Plan four years ago, our main goal was to create a living, breathing document. We envisioned a road map, developed with the help of partners across the state, to guide the future of the agency.

We wanted to ensure that strategic planning was an open process with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies.

We wanted to make strides toward developing a community-based service system which focuses on evidence-based practices and improves access to care.

We wanted to use available resources effectively and efficiently to meet our goals and improve our current service system.

By reviewing the quarterly and annual reports from the last three years, it is easy to see that we are steadily making progress in meeting our goals.

With the assistance of our dedicated staff and partners, we have been able to achieve much even during difficult budget times. The economic climate has changed since the first Strategic Plan was crafted. During such a serious budget crisis, it continues to be a difficult task to transform the public mental health system to a more community-based, recovery-driven system. But, we will continue to move forward to the best of our ability.

Now is the time to push forward to help the thousands of Mississippians in need of our services. It is important not only to have a Strategic Plan, but to stay the course and continue the Plan's actions. The five goals within this Plan reflect the future course of DMH and the public mental health system. My hope is that you will continue to work with us in supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual or developmental disabilities one person at a time.

Edwin C. LeGrand III  
DMH Executive Director

# Table of Contents

---

Executive Summary	Page 1
Mission, Vision, and Values	Page 3
Philosophy	Page 4
Core Competencies	Page 5
Organizational Overview	Page 6
Services and Supports Overview	Page 8
Goals and Objectives	Page 12
Future Goals	Page 33
Implementation	Page 35
Acknowledgements	Page 36
Acronyms	Page 37

# Executive Summary

---

The purpose of the Strategic Plan is to drive the transformation of the mental health system into one that is outcomes-oriented and community-based. The Board's 2012 Strategic Planning Subcommittee consisted of Board members Dr. Margaret Cassada, Mr. George Harrison, Mr. Johnny Perkins, and Ms. Rose Roberts; Central Office staff liaison, Ms. Lisa Romine; Clinical Services Director, Dr. Lydia Weisser, MSH; and Ms. Lynda Stewart, DMH Division of Children and Youth.

The Board's Strategic Planning Subcommittee is charged to review annually and revise as necessary the Strategic Plan, which serves as a map for guiding the continuing transformation of the DMH service system. The Board of Mental Health intends for the Strategic Plan to be a flexible, living document which meets the needs of the people we support and enables us to face the challenges of an ever-changing environment. The Strategic Plan is an essential tool for system transformation.

Work on the annual review began with the goals' objectives and action plans. The five Goal Leaders were asked to solicit the help of their goal team members and others to make recommendations on which objectives/action plans to include, keeping in mind the need to show observable and measurable outcomes and taking into account current activities and the changing environment. These Goal Leaders were Kelly Breland and Trisha Hinson, Goal 1; Jake Hutchins and Sandra Parks, Goal 2; Ashley Lacoste and Thaddeus Williams, Goal 3; Dr. Mardi Allen, Goal 4; and James Dunaway, Goal 5. DMH Bureau Directors, Lisa Romine, Kris Jones, Matt Armstrong, Diana Mikula, and Jerri Avery, also provided input into the revision as did Wendy Bailey, DMH Central Office. During the review of each goal, objectives/action plans were removed from the Plan if these measures had been completed, were duplicated in another goal, or are now part of ongoing DMH activities. Timelines and performance indicators were also reviewed and revised as necessary. In response to emerging issues, new objectives and action plans were added as well.

The Goal Leaders for FY 2012 then presented their proposed revisions to the Board's Strategic Planning Subcommittee. The Subcommittee discussed each goal and made suggestions for revisions. A draft Strategic Plan was then reviewed by the Subcommittee and Board prior to approval. A summary of the finalized goals follows.

**Goal 1** calls for DMH to continue to execute cost reduction measures and enhance its accountability and management practices to ensure the most efficient use of its resources. The goal also emphasizes the need to maximize funding through grants and available Medicaid waiver programs and services. 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 vision of individuals receiving services having a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 2 also highlights the transformation to a community-based service system. This transformation is woven throughout the

entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long-term community supports and other specialized services along with services to help individuals transition from institutions to the community. Goal 2 provides a foundation on which DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

**Goal 3** addresses the methods by which DMH intends to increase individuals' access to care and services statewide. Goal 3 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 4** establishes the use of evidence-based or best practice models and service outcomes. DMH embraces the importance of identifying and implementing the most cost-effective EBP models available 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 5** focuses on using data and available technology in decision making. DMH will enhance its ability to communicate effectively and share data and information across the agency. DMH will fully implement and utilize its Central Data Repository project and continue activities to establish Electronic Health Records and a Health Information Exchange. With better data and analysis, decision making will be enhanced.

Changes in the mental health system are occurring even though the environment in which the mental health system operates continues to offer challenges. It is the obtainment of our vision of a community-based service system that keeps DMH's dedicated staff and engaged stakeholders staying the course.

# 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, outcome 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.

# Philosophy

---

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service, and support options for adults and children with mental illness or emotional disturbance, alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

# 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 persons of this state with mental illness, emotional disturbance, alcoholism, drug dependence, and an intellectual disability; 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 intellectual disability 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 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 Workforce Development and Training**

**Bureau of Alcohol and Drug Services**

**Bureau of Quality Management, Operations and Standards**

**Bureau of Intellectual and Developmental Disabilities**

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

## **DMH-Operated Facilities and Community Services Programs**

DMH directly operates five psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual and developmental disabilities, and one specialized facility that serves adolescents with intellectual and developmental disabilities. 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:*** DMH administers and operates five state psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual/developmental disabilities, and one facility that serves adolescents with intellectual and developmental disabilities. These facilities serve specified populations in designated counties/service areas of the state.

The psychiatric facilities provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance abuse. These facilities include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. 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 Specialized Treatment Facility is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment. Central Mississippi Residential Center is a residential center for persons with mental illness.

The facilities for persons with intellectual/developmental disabilities provide residential services. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center. The facilities are also a primary vehicle for delivering community services throughout Mississippi. Mississippi Adolescent Center is a specialized facility for adolescents with intellectual/developmental disabilities.

**Regional community mental health centers (CMHCs):** 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 CMHCs. 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. These programs are certified by DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol/drug abuse services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

## Available Services and Supports

Both facility and community-based services and supports are available through DMH. 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	Nursing Home Services
Intermediate Psychiatric Care	Medical/Surgical Hospital Services
Continued Treatment Services	Forensic Services
Adolescent 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	Special Education
Psychological Services	Recreation
Social Services	Speech/Occupational/Physical Therapies
Medical/Nursing Services	Vocational Training
Diagnostic and Evaluation Services	Employment Services
Community Services Programs	

### **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	Peer Support Services
Psychosocial Rehabilitation	Community Support Services
Consultation and Education Services	Assertive Community Treatment
Emergency Services	Medication Management
Pre-Evaluation Screening/Civil Commitment Exams	Crisis Services
Outpatient Therapy	Supervised Housing
Case Management Services	Physician/Psychiatric Services
Halfway House Services	SMI Homeless Services
Group Home Services	Drop-In Centers
Acute Partial Hospitalization	Day Support
Elderly Psychosocial Rehabilitation	Individual and Family Education and Support

## Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Home	Day Treatment
Treatment Foster Care	Outpatient Therapy
Prevention/Early Intervention	Physician/Psychiatric Services
Crisis Services	MAP (Making A Plan) Teams
Crisis Residential	Family Education and Support
Targeted Case Management	Wraparound Facilitation
Peer Support (Family & Youth)	Intensive Outpatient Psychiatric Services
Community Support Services	Respite Services

## Services for People with Alzheimer's Disease and Other Dementia

Adult Day Centers  
Caregiver Training

## Services for People with Intellectual/Developmental Disabilities

Early Intervention	ID/DD Waiver Behavioral Support/Intervention
Community Living Programs	ID/DD Waiver In-Home Nursing Respite
Work Activity Services	ID/DD Waiver ICF/MR Respite
Supported Employment Services	ID/DD Waiver Day Services - Adult
Day Support	ID/DD Waiver Prevocational Services
Diagnostic and Evaluation Services	ID/DD Waiver Support Coordination
Community Support Services	ID/DD Waiver Occupational, Physical, and Speech/Language Therapies
ID/DD Waiver Home and Community Supports	
ID/DD Waiver Community Respite	

## Alcohol and Drug Services

Detoxification Services  
Chemical Dependency Units  
Outpatient Services  
DUI Diagnostic Assessment Services

Prevention Services  
Primary Residential Services  
Transitional Residential  
Outreach/Aftercare

## 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](http://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 five-year goals to address the transformation of the DMH service system. These goals address the key issues of accountability/efficiency, a person-centered and person-driven system, access, community services/supports, outcomes, partnerships, and information management.

The goals and objectives will guide DMH's actions in moving toward a community-based service system. Each goal's objectives include action plans, performance measures, timelines, and responsible parties. Furthermore, unless specified, these goals and objectives are inclusive of the populations DMH is charged to serve, and services developed and/or provided will take into account the cultural and linguistic needs of these diverse populations.

## **The system-wide goals are as follows:**

- GOAL 1**     *Maximize efficient and effective use of human, fiscal, and material resources*
  
- GOAL 2**     *Continue transformation to a person-driven, community-based service system*
  
- GOAL 3**     *Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers*
  
- GOAL 4**     *Implement evidence-based or best practice models and service outcome measures*
  
- GOAL 5**     *Utilize information/data management to enhance decision making and service delivery*

# Goal 1 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
		2013	2014	2015	2016	2017	
a) Continue to implement proven cost reduction measures across DMH programs/services	Amounts and relative percentages realized from expenditure reductions projects	2013	2014	2015	2016	2017	Bureau of Administration, assigned DMH staff
b) Implement at least one new Expenditure Reduction Project each year	By 2017, five projects developed and implemented with projected cost reductions reported	2013	2014	2015	2016	2017	Bureau of Administration, assigned DMH staff
c) Determine personnel needed to transform the service system	Increase in types and numbers of community-based support staff	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BWDT
d) Increase efficient use of human resources by developing innovative cost-reduction measures concerning personnel (i.e., job sharing, flex scheduling of staff, etc.)	Consolidated report with expenditure reductions and/or efficiencies in human resources	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BWDT

## Objective 1.2 Maximize funding opportunities

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Assist the Division of Medicaid with submission of a Medicaid State Plan Amendment to include services allowed under Section 1915i	Waiver request finalization and submission	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BQMOS
b) Apply for at least two new grants or additional funding in targeted areas: infrastructure and capacity building	Number of grants applied for and increase in the amount of grant dollars obtained	2013	2014	2015	2016	2017	Assigned DMH Staff
c) Collaborate with Division of Medicaid to amend the Medicaid State Plan initially for IDD services to provide a full array of person-centered services (respite services and MAP teams)	Medicaid State Plan amendments submitted	2013	2014	2015	2016	2017	BIDD

Action Plan	Performance Indicator	Target Year					Responsibility
d) Maximize use of Elderly/Disabled Waiver to provide services/programs for individuals with Alzheimer's Disease	Increased number of individuals served in Garden Park using the Elderly/Disabled Waiver funds	2013	2014	2015	2016	2017	BCS
e) Expand use of Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program services for children and youth	Increased number of children served by CMHCs receiving EPSDT services	2013	2014	2015	2016	2017	BCS, BIDD
f) Investigate the need for tiered service options	Needs assessment conducted to determine services that could be provided through tiered options	2013	2014	2015	2016	2017	BIDD, BCS

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

Action Plan	Performance Indicator	Target Year					Responsibility
a) Maximize stakeholder input by streamlining the number of required task forces and steering committees	One representative committee for stakeholder input that meets requirements of applicable statutes or policies	2013	2014	2015	2016	2017	BCS, BIDD, BADS
b) Increase effectiveness of coordination of MAP teams	State Level Coordinator hired for C&Y and Adult MAP Teams	2013	2014	2015	2016	2017	BCS
c) Establish a DMH quality management council to assist DMH with identification of trends and patterns among all DMH certified providers	Quality management council established	2013	2014	2015	2016	2017	BCS, BQMOS, BIDD, BADS
d) Implement resource allocation strategy to support EBP/BPs and service outcome models	Funding amounts (dollars) reallocated, itemized by service, and number and type of EBP/BPs in use	2013	2014	2015	2016	2017	BCS, BIDD, BADS

Action Plan	Performance Indicator	Target Year					Responsibility
e) Publish an annual report that benchmarks like programs with established performance indicators/outcomes/national core indicators	Core indicator database completed and benchmarking begun	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BQMOS
f) Increase percentage of funding allocation to priority services (crisis services, housing, supported employment, and early intervention/prevention)	Funding amounts (dollars) allocated to top three priorities	2013	2014	2015	2016	2017	BCS, BIDD, BADS

## Goal 2 Strengthen commitment to a person-driven, community-based service system

### Objective 2.1 Expand meaningful interaction of self advocates and families in designing and planning at the system level

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Provide opportunities for individuals and family members to participate in program development, service planning and recovery training	Active participation of peers and family members on Advisory Councils	2013	2014	2015	2016	2017	DCS and all DMH
b) Provide statewide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values	Increased knowledge of staff and increase in positive responses to the Council on Quality and Leadership's (CQL) 21 Personal Outcome Measures ©	2013	2014	2015	2016	2017	DCS, BIDD, BQMOS, C&Y
c) Determine system's responsiveness to individual needs and desired outcomes	100% of certified programs evaluated according to the CQL's 21 Personal Outcome Measures ©	2013	2014	2015	2016	2017	BQMOS, DCS and CQL Review Team
d) Incorporate Peer Recovery Supports Services into core services in DMH Operational Standards	Peer Recovery Specialist employed by DMH certified providers	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BQMOS
e) Incorporate Peer Supports Services into core services in DMH Operational Standards	Certified Peer Support Specialist employed by DMH certified providers	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BQMOS
f) Evaluate effect of implementation of CQL's 21 Personal Outcome Measures © on the system's transformation to a recovery and resiliency model	Programs that were evaluated and trained met or exceeded national norms	2013	2014	2015	2016	2017	DCS , CQL Review Team, BCS, BIDD, BADS, BQMOS
g) Expand representation in the Office of Consumer Support to include at least one peer specialist or parent advocate for each population served by DMH	Representative for IDD included	2013	2014	2015	2016	2017	DCS , BIDD, BQMOS

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
h) Identify barriers and make recommendations concerning the state's implementation of CQL's 21 Personal Outcome Measures ©	CQL's 21 Personal Outcome Measures © re-evaluated to determine if the state met the threshold and the need to add or delete Personal Outcome Measures	2013	2014	2015	2016	2017	Bureau Directors, BQMOS
i) Implement an action plan for next steps based on the recommendations made regarding CQL's 21 Personal Outcome Measures	Action Plan for next steps developed and implementation begun	2013	2014	2015	2016	2017	Bureau Directors, BQMOS

**Objective 2.2 Develop a comprehensive crisis response system**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Provide Crisis Stabilization Unit (CSU) services through each CMHC region	By end of FY 2016, each CMHC region will have a CSU	2013	2014	2015	2016	2017	BCS
b) Evaluate CMHC-operated crisis stabilization units based on defined performance indicators for diversion, length of stay, and recidivism	Report of increase in diversion rate, length of stay, and recidivism rate	2013	2014	2015	2016	2017	BCS, BQMOS
c) Provide readily available community crisis services	24/7 emergency/crisis services provided by all 15 CMHCs for all 82 counties	2013	2014	2015	2016	2017	BCS, BIDD, BADS
d) Investigate the feasibility and impact of providing crisis detoxification services at CSUs	Report developed outlining the impact of providing crisis detoxification services at CSUs	2013	2014	2015	2016	2017	BADS, BCS

Action Plan	Performance Indicator	Target Year					Responsibility
e) Develop transition/step-down residential options for people leaving crisis stabilization units	Designation of at least two crisis apartment beds per CSU to assist individuals in transition back into the community	2013	2014	2015	2016	2017	BCS
f) Develop crisis support plans for individuals as a standard component of care and mitigation strategy	Crisis Support Plan developed for each person at risk of crisis, frequent user of inpatient services, or transitioning from inpatient/more restrictive placement or environment	2013	2014	2015	2016	2017	BIDD, BCS, BADS
g) Provide crisis and emergency respite services to people with intellectual/developmental disabilities	Pilot one ICF/MR group home or cottage on campus to be used solely for crisis respite services	2013	2014	2015	2016	2017	BIDD
h) Partner with CSUs operated by CMHCs to furnish crisis-oriented, specialized behavioral services on an as-needed basis for people with dual diagnosis of SMI/IDD	Crisis services provided at CSUs for persons with dual diagnosis	2013	2014	2015	2016	2017	BCS, BIDD

**Objective 2.3 Increase statewide availability of safe, affordable and flexible housing options and other community supports for individuals**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Acquire sufficient staff time, training and resources to continue the development of service linkages with multiple housing partners at the state and regional levels	Support staff assigned to DMH Division of Housing and Community Living	2013	2014	2015	2016	2017	BCS, BIDD, BADS
b) Identify and coordinate an array of supportive services needed to sustain individuals in permanent housing in local communities	By 2017, at least 500 persons received supported housing services/ supports across the state	2013	2014	2015	2016	2017	BCS, BIDD, BADS
c) Provide Bridge Funding for supported housing	At least 20 individuals received Bridge Funding to secure supported housing each year	2013	2014	2015	2016	2017	BCS, BIDD, BADS

**Objective 2.4 Provide community supports for persons transitioning to the community through participation in the Bridge To Independence project**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Expand ID/DD Waiver services to enable individuals with IDD residing in DMH facilities to transition into the community using Bridge to Independence services	By 2016, 138 people transitioned from ICF/MRs to community	2013	2014	2015	2016	2017	BIDD
b) Increase number served in ID/DD Waiver each year from those on the waiting list	ID/DD Waiver enrollment increased by 5% each year	2013	2014	2015	2016	2017	BIDD
c) Transfer people with SMI from nursing homes to community using Bridge To Independence services	By 2016, 72 people transitioned from nursing facilities to community	2013	2014	2015	2016	2017	BCS, BIDD
d) Transition Coordinators will establish interagency, multidisciplinary transition teams at the state ICF/MRs to assist individuals in making a seamless transition to community-based services	By 2014, five Transition Teams operating	2013	2014	2015	2016	2017	BIDD

**Objective 2.5 Provide long-term community supports**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Expand PACT teams to support the integration and inclusion of persons needing long-term psychiatric care	By 2017, five additional PACT teams funded across the state	2013	2014	2015	2016	2017	BCS
b) Provide Community Support Teams to promote and support the independent living of individuals served	15 Community Support Teams funded and developed across the state	2013	2014	2015	2016	2017	BCS

## Objective 2.6 Provide supported employment services

Action Plan	Performance Indicator	Target Year					Responsibility
a) Increase number of individuals assisted with employment	By 2017, at least 500 individuals with SMI/SED/A&D/IDD obtained jobs	2013	2014	2015	2016	2017	BCS, BIDD, BADS
b) Assist in the reentry of individuals with mental illness into in the workplace	By 2017, Employment Specialists employed by DMH certified providers	2013	2014	2015	2016	2017	BCS, BIDD, BADS
c) Increase supported employment for individuals with IDD and decrease reliance on Work Activity Services	Number of people transitioned to supported employment from Work Activity	2013	2014	2015	2016	2017	BIDD

## Objective 2.7 Expand specialized services when funds become available

Action Plan	Performance Indicator	Target Year					Responsibility
a) Increase and improve integrated treatment service options for co-occurring disorders in adults with SMI and children/youth with SED (SMI/A&D, SED/A&D, SMI/IDD, SED/IDD)	Number of co-occurring integrated treatment sites increased	2013	2014	2015	2016	2017	BCS, BIDD, BADS
b) Increase the number of transition-aged youth/young adults with SED served in the four MTOP project sites	By 2016, increased by 200 youth with 50 youth per year	2013	2014	2015	2016	2017	BCS
c) Increase availability of in-home respite for caregivers of individuals with SED	Number of respite providers added and number served	2013	2014	2015	2016	2017	BCS, BIDD

**Objective 2.7 Expand specialized services when funds become available**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
d) Expand early intervention assessments for children 0 - 5 years of age in CMHCs for identification of developmental disabilities including SED	Implementation and number tracked of children who receive a Preschool and Early Childhood Functional Assessment Scale (PECFAS)	2013	2014	2015	2016	2017	BCS, BIDD
e) Initiate statewide guidelines to assess individuals with an intellectual/developmental disability for dementia to determine appropriate care approaches	Policy for dementia screenings developed and implemented within all DMH facilities	2013	2014	2015	2016	2017	BIDD, BCS, BMH

## Goal 3 Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers

### Objective 3.1 Establish equitable and timely access to services statewide

Action Plan	Performance Indicator	Target Year					Responsibility
a) Implement planning lists procedures to better identify the types and locations of needed services/supports in order to increase options for home and community-based service provision	Utilization of integrated planning lists for BIDD and BMH	2013	2014	2015	2016	2017	BIDD, BMH
b) Develop strategies to address barriers to timely access	Strategies developed to reduce average length-of-wait times in community service programs	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BMH
c) Increase access to mental health care/services through expanded use of telemedicine	By 2014, all 15 CMHCs have access to telemedicine/telehealth	2013	2014	2015	2016	2017	BCS
d) Develop a searchable database on DMH's Web site for the public to locate available services in their community	Database developed and available on DMH website	2013	2014	2015	2016	2017	IS, OCS, Director of Public Information
e) Implement statewide system of standardized assessment for persons in the ID/DD Waiver for use in determining level of service needs for people to live successfully at home and in the community	Standardized assessment tool identified and implemented	2013	2014	2015	2016	2017	BIDD
f) Develop ID/DD Waiver rate-setting methodology to ensure provider reimbursement rates are appropriate and equitable for the services being provided	New service rates established	2013	2014	2015	2016	2017	BIDD

**Objective 3.2 Expand and increase effectiveness of interagency and multidisciplinary approaches to service delivery**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Increase partnership activities between local entities and community providers such as hospitals, holding facilities, CSUs and CMHCs to establish triage, treatment, and diversion plans	MOUs and documentation of outreach and action accomplished through mutual efforts	2013	2014	2015	2016	2017	BCS, BIDD, BADS, BMH
b) Collaborate with the Veterans Administration (VA) to increase the provision of A&D services to veterans within the local community	Contracting of two or more regional CMHCs and free-standing programs with the VA for bed space for veterans in the community	2013	2014	2015	2016	2017	BADS
c) Expand MAP teams for children and youth with SED and IDD	By 2017, MAP Teams available in all 82 counties	2013	2014	2015	2016	2017	BCS, BIDD
d) Increase the utilization and practice of Wraparound for children and youth with SED and/or IDD	Wraparound model utilized by each certified CMHC for those children/youth and their families deemed necessary	2013	2014	2015	2016	2017	BCS, BIDD
e) Expand adult MAP teams as funding is available	By 2017, at least one adult MAP Team available in all 15 CMHC regions	2013	2014	2015	2016	2017	BCS
f) Facilitate work with state and local partnerships to increase jail diversion programs	Increased number of jail diversion programs, mental health courts, holding facilities and CIT programs	2013	2014	2015	2016	2017	BCS

Action Plan	Performance Indicator	Target Year					Responsibility
g) Continue partnership with the Mississippi Transportation Initiative	Increased availability of transportation	2013	2014	2015	2016	2017	BCS, BIDD
h) Develop strategies to facilitate integration of mental illness, IDD, and addiction services with primary health care	Seek funding sources to increase use of integrated services	2013	2014	2015	2016	2017	BCS, BIDD, BADA
i) Continue development of multi-agency comprehensive approach for substance abuse prevention among adolescents	Developed joint efforts with community partners	2013	2014	2015	2016	2017	BCS, BIDD, BADS
j) Conduct person-centered planning training at all DMH facilities and with all DMH certified providers and other interested parties (advocates, individuals, families) directed at developing resources for individuals transitioning from institutional care to the community	By 2014, training conducted at all 12 DMH facilities	2013	2014	2015	2016	2017	BIDD, BCS
k) Implement person-centered planning as tool to move people from institutional settings to the community	Number of PCPs conducted and number of successful transitions	2013	2014	2015	2016	2017	BIDD, BCS
l) Utilize person-centered planning as tool to support planning for individuals living in the community	100% of all community service programs participating in person-centered planning	2013	2014	2015	2016	2017	BIDD, BCS
m) Develop collaboration between faith-based organizations and mental health system to enhance access to services	Piloted a faith-based Emotional Fitness Center between a local faith-based organization and a mental health provider	2013	2014	2015	2016	2017	BCS, BADS

Action Plan	Performance Indicator	Target Year					Responsibility
n) Begin work with the Department of Rehabilitation Services to increase supported employment services for people with IDD and SMI	MOU or interagency agreement developed	2013	2014	2015	2016	2017	BIDD, BCS
o) Continue to provide support and assistance to promote certification of holding facilities in each county	Technical assistance provided to five counties per quarter	2013	2014	2015	2016	2017	BCS
p) Initiate meeting with Department of Education to discuss ways in which school districts can provide support to students returning to the local districts from an institution	Meeting held and future plans delineated	2013	2014	2015	2016	2017	BIDD
q) Partner with appropriate agencies to develop educational materials to educate DMH and CMHC staff, adults with an intellectual/developmental disability, and families/caregivers on the signs of dementia and related disorders	Partnerships and materials developed, materials disseminated	2013	2014	2015	2016	2017	BIDD, BCS

## Goal 4 Implement use of evidence-based or best practice models and service outcome measures

### Objective 4.1 Analyze the efficacy and cost benefits associated with implementation of evidence-based or best practices

Action Plan	Performance Indicator	Target Year					Responsibility
a) Establish a DMH Evidence-Based and Best Practices Evaluation Council to analyze cost benefits of EBP/BP models, support implementation and training, and evaluate effectiveness and efficiency of models	Council reports and recommendations made	2013	2014	2015	2016	2017	Representative from each programmatic bureau, Clinical Services Liaison
b) Develop a summary of grant programs which currently use EBP/BP models - Inventory of existing EBP/BPs	Grant programs summary developed	2013	2014	2015	2016	2017	DMH Evidence-Based and Best Practices Evaluation Council
c) Develop a report of cost benefit for at least one program in each service population based on comparative national data	Cost benefit report developed	2013	2014	2015	2016	2017	DMH Evidence-Based and Best Practices Evaluation Council
d) Based on analyses, make recommendations regarding programmatic and cost effectiveness of programs	Report of recommendations developed	2013	2014	2015	2016	2017	DMH Evidence-Based and Best Practices Evaluation Council

**Objective 4.2 Support implementation and training of evidence-based or best practices**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Increase the frequency of workforce development opportunities offered to providers (by DMH) focused on EBP/BP models	At least 5% increase in EBP/BP training opportunities each year and demonstrated increase in knowledge of participants	2013	2014	2015	2016	2017	BWDT, BMH, BIDD, BADS
b) Increase the use of e-learning to ensure Central Office staff are well informed and competent in EBP/BP models applicable to their division responsibilities	10 hours of CEs required each year	2013	2014	2015	2016	2017	Bureau Directors
c) Involve stakeholders by conducting focus groups with consumers, family members and providers regarding their perspective for changes/recommendations	Report of survey results with feedback from stakeholders	2013	2014	2015	2016	2017	DMH Evidence-Based and Best Practices Evaluation Council
d) Develop an e-library of relevant articles, books, etc., to assist in the full implementation of EPB/BP models	Access to e-library at all DMH facilities	2013	2014	2015	2016	2017	IT, Clinical Services Liaison

**Objective 4.3 Evaluate the effectiveness and efficiency of the evidence-based or best practice models relevant to the required service outcomes**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Develop an assessment process to evaluate specific positive service outcomes for each of the core services and DMH consistent with the system-level performance measures developed by the Legislative Strategic Planning Committee	Assessment process developed	2013	2014	2015	2016	2017	BQMOS, DMH Evidence-Based and Best Practices Evaluation Council
b) Incorporate positive service outcome evaluation criteria into the program review process conducted by the DMH monitoring team	Evaluation of service outcomes are reported in monitoring reports	2013	2014	2015	2016	2017	BQMOS
c) Analyze outcomes to refine effective utilization practices and identify deficits and make adjustments as needed	Report findings to the DMH Strategic Planning Subcommittee	2013	2014	2015	2016	2017	BQMOS, DMH Evidence-Based and Best Practices Evaluation Council
d) Review any plan of correction for programs offering core services that are utilizing EBP/BPs but have failed to accomplish positive service outcomes	Plans received and determined if acceptable by BQMOS	2013	2014	2015	2016	2017	BMH, BCS, BIDD, BADS, BQMOS
e) Establish a Clinical Research, Development and Training Collaborative to ensure timeliness in adoption of the most effective and efficient practice models available	Yearly report to DMH Strategic Planning Subcommittee	2013	2014	2015	2016	2017	BWDT, IT, Clinical Services Liaison

# Goal 5 Utilize information/data management to enhance decision making and service delivery

## Objective 5.1 Maximize reporting potential of collected data

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Refine/evaluate reports on client level data from CDR for appropriateness/clinical-programmatic	Reports reviewed for appropriateness	2013	2014	2015	2016	2017	Clinical/service staff IS Staff
b) Modify CDR to allow for capturing length-of-wait data	Included "waiting" as a service in order to track length of wait	2013	2014	2015	2016	2017	IS Staff
c) Disseminate monthly reports when/where necessary (admissions, discharges, recidivism)	Reports produced and disseminated	2013	2014	2015	2016	2017	IS Staff
d) Generate other needed reports based on data elements currently collected for client tracking	Reports produced and disseminated	2013	2014	2015	2016	2017	IS Staff
e) Expand reporting capabilities of the CDR by creating procedures for requesting one-time reports	Availability of ad hoc reports	2013	2014	2015	2016	2017	IS Staff
f) Eliminate duplication in data collection and reporting (electronic and manual)	Streamlined data collection among bureaus and divisions	2013	2014	2015	2016	2017	IS Staff
g) Create applications for viewing and creating reports from website	Website reporting	2013	2014	2015	2016	2017	IS Staff

**Objective 5.2 Develop/expand an electronic collection and reporting system for new reports**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Determine what software/program will be used across all bureaus/facilities	Report summarizing recommendations	2013	2014	2015	2016	2017	DMH Representative
b) Determine what new reports are required (i.e., Annual Operational Plan, Certification Visit Reports, Provider Management System, Outcome, Managed Care, Disparity Data, etc.) and for whom (i.e. Central Office, C & Y, CMHCs, etc.)	Recommendation made on needed reports	2013	2014	2015	2016	2017	Executive Director, Bureau/Division Directors
c) Define data for required report	Data elements identified	2013	2014	2015	2016	2017	DMH Representative
d) Design standardized reports with timelines for implementation	Reports designed	2013	2014	2015	2016	2017	DMH Representative
e) Implement collection and reporting	Reports produced	2013	2014	2015	2016	2017	DMH Representative

**Objective 5.3 Establish an electronic exchange of health information between DMH facilities and programs, and MS Health Information Network (MSHIN)**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Determine DMH participation cost for MSHIN	Calculation of cost per facility to participate in MSHIN	2013	2014	2015	2016	2017	DMH Representative

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
b) Determine DMH facilities to join MSHIN	As approved by DMH, number of facilities which join MSHIN	2013	2014	2015	2016	2017	DMH Representative
c) Report MSHIN Board actions quarterly	Make recommendations for changes/revisions based on the Board's actions	2013	2014	2015	2016	2017	DMH Representative
d) Determine communication pathway among HIE and EHR	Post evaluation, provided recommendation of pathways	2013	2014	2015	2016	2017	DMH Representative

**Objective 5.4 Establish electronic health record (EHR) systems at DMH facilities and programs (as mandated and approved by DMH)**

Action Plan	Performance Indicator	Target Year					Responsibility
		2013	2014	2015	2016	2017	
a) Develop strategy and priority for implementing EHR systems at DMH facilities and programs	Implementation activities and time frame developed	2013	2014	2015	2016	2017	Goal Objective Leader, DMH Electronic Health Record Committee
b) Pursue adoption, implementation and upgrades (A/I/U) of EHR	100% implementation of EHR at qualifying programs	2013	2014	2015	2016	2017	Goal Objective Leader, DMH Electronic Health Record Committee

**Objective 5.5 Develop a Health Information Technology (HIT) strategy for DMH including policies, standards, and technical protocols while incorporating cost-saving measures**

Action Plan	Performance Indicator	Target Year					Responsibility
a) Perform Network Security Audit	100% participation and remediation of network security of DMH Central Office and facilities	2013	2014	2015	2016	2017	Goal Leader and Facility Director (or as designated)
b) Standardize IT Policies and disaster recovery Standard Operating Procedures (SOPs)	Review and standardization of 100% of IT policies and SOPs	2013	2014	2015	2016	2017	Goal Leader and Facility Director (or as designated)
c) Determine future technology needs	Standardization of technology use and dollars saved	2013	2014	2015	2016	2017	Goal Leader and Facility Director (or as designated)

# Future Goals

## Fiscal Year 2018 and Beyond...

The goals and objectives for Fiscal Years 2013-2017 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 2018 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 for implementation 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*

*Obtain new funding for emerging services*

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

### Goal 2 Continue transformation to a person-driven, community-based service system

*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 specialists 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.*

*Create a seamless system of community care for individuals with mental health needs*

*Provide crisis services statewide for IDD and A&D*

*Assess need for emerging services*

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

### **Goal 3 Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers**

*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 availability of services at partner locations*

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

*Increase collaboration and funding from local governments*

### **Goal 4 Implement evidence-based or best practice models and service outcome measures**

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

*Establish a research and development center*

*Establish a “Statewide Learning Community” to assist programs in maintaining competent staff*

### **Goal 5 Utilize information/data management to enhance decision making and service delivery**

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

*Develop electronic identification card system*

# Implementation

---

With the Board of Mental Health's approval of the Strategic Plan, work will begin on FY 2013 action plans on July 1, 2012. As in the previous years, implementation of the Plan is goal-based. Goal leaders and team members are assigned to each of the five goals. These dedicated individuals will work on FY 2013's action plans to meet measurable and observable performance indicators.

While progress is ongoing, quarterly reports will be developed and presented to the Board. Reports will also be posted on DMH's Web site for the public. Quarterly reports provide a tracking mechanism to show progress and areas which need to be addressed.

Funding continues to be a roadblock to full implementation of a more community-based and recovery-focused system. Research, partnerships and creative thinking are necessary to overcoming this and other challenges. By working with partners statewide, we can reach our ultimate goal of supporting a better tomorrow for individuals who have mental illness, intellectual or developmental disabilities, substance abuse problems, and Alzheimer's disease and other dementia.

# 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 acknowledgement includes not only DMH staff, but stakeholders and others in the mental health system. Their dedication can clearly be seen in the development and implementation of the Plan. 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.

## ***Goals, Objectives, and Action Plans***

Lisa Romine, Bureau of Interdisciplinary Programs  
Dr. Lydia Weisser, Department of Mental Health Medical Director  
Kelly Breland, Mississippi State Hospital  
Trisha Hinson, Bureau of Intellectual and Developmental Disabilities  
Ashley Lacoste, Bureau of Intellectual and Developmental Disabilities  
Veronica Vaughn, Bureau of Quality Management, Operations and Standards  
Thaddeus Williams, Bureau of Community Services  
Sandra Parks, Bureau of Community Services  
Jake Hutchins, Bureau of Community Services  
Dr. Mardi Allen, Clinical Services Liaison  
Sabrina Young, South Mississippi State Hospital  
James Dunaway, DMH Chief Information Officer  
Wendy Bailey, Central Office

## ***Strategic Plan Document Preparation***

Lisa Romine, Bureau of Interdisciplinary Programs  
Wendy Bailey, Central Office

# Acronyms

---

A& D	Alcohol and Drug
BADS	Bureau of Alcohol and Drug Services
BCS	Bureau of Community Services
BIDD	Bureau of Intellectual and Developmental Disabilities
BMH	Bureau of Mental Health
Board	Board of Mental Health
BP	Best Practices
BQMOS	Bureau of Quality Management, Operations and Standards
B2I	Bridge to Independence
BWDT	Bureau of Workforce Development and Training
C & Y	Children and Youth
CDR	Central Data Repository
CIT	Crisis Intervention Training
CMHC	Community Mental Health Centers
CO	Central Office
CSU	Crisis Stabilization Unit
CQL	Council on Quality and Leadership
DMH	Department of Mental Health
EBP	Evidence-Based Practice
EHR	Electronic Health Records
HIE	Health Information Exchange
ICF/MR	Intermediate Care Facilities for the Mental Retarded
IDD	Intellectual/Developmental Disabilities
IS	Information System
IT	Information Technology
ITS	Information Technology Service
LPC	Licensed Professional Counselor
MAP Teams	Making-a-Plan Teams
MSHIN	Mississippi Health Information Network
MOU	Memorandum of Understanding
MTOP	Mississippi Transitional Outreach Program
OCS	Office of Consumer Support
PACT	Program of Assertive Treatment
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOP	Standard Operating Procedures

# Environmental Factors and Plan

## 11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

---

### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/social)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Are you considering any of the following:

Targeted services for veterans  Yes  No

c) Expansion of services for:

- (1) Adolescents  Yes  No
- (2) Other Adults  Yes  No
- (3) Medication-Assisted Treatment (MAT)  Yes  No

## **Criterion 2**

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Are you considering any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, custody issue  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

MS DMH- Bureau of Alcohol and Drug Services has developed an interim data collection tool through DataGadget. In this program, bed capacity at all certified facilities will be shown. Data is real-time but entered by hand each time an individual is admitted or discharged. The long-range goal includes the collection of intake and discharge data through the submission of electronic health records to a state-level database system. In addition, sub-grantee funding is withheld from agencies that do not adhere to guidelines.

All SABG-funded programs for women's services are required to respond within 48 hours of seeking treatment. If treatment is unavailable due to a program's insufficient capacity, the program must immediately provide interim services or refer the individual to DMH for assistance.

Providers must offer interim services immediately to pregnant women when the appropriate level of care is not available within 14 days. Interim services are to reduce the adverse health effects of substance abuse, promote the health of the client, and reduce the risk of transmission of disease. If treatment is unavailable, interim treatment should be arranged within 48 hours.

Minimum interim services include counseling and education about HIV and tuberculosis:

- risks of needle-sharing,
- risks of transmission to sexual partners and infants,
- steps that can be taken to ensure that HIV transmission does not occur, and
- referral for HIV and TB treatment services.

For pregnant women, interim services should include: counseling on the effects of alcohol and drug use on the fetus, and referrals for prenatal care.

DMH further requires all treatment providers funded by SABG to publicized by public service announcements (radio/television) and/or street outreach programs, the availability of treatment to pregnant women.

- Pregnant women who inject drugs
- Pregnant women who misuse substances

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
  - a) 90 percent capacity reporting requirement  Yes  No
  - b) 14-120 day performance requirement with provision of interim services  Yes  No
  - c) Outreach activities  Yes  No
  - d) Syringe services programs  Yes  No
  - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
2. Are you considering any of the following:
  - a) Electronic system with alert when 90 percent capacity is reached  Yes  No
  - b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
  - c) Use of peer recovery supports to maintain contact and support  Yes  No
  - d) Service expansion to specific populations (military families, veterans, adolescents, older adults)  Yes  No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.  
 We require all certified providers to give priority to IV drug users. The bed capacity and availability is kept in DataGadget. We identify compliance issue and develop corrective actions based on monitoring visits. A corrective action plan is required for all services not meeting the operational standards.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  Yes  No
2. Are you considering any of the following:
  - a) Business agreement/MOU with primary healthcare providers  Yes  No
  - b) Cooperative agreement/MOU with public health entity for testing and treatment  Yes  No
  - c) Established co-located SUD professionals within FQHCs  Yes  No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**Early Intervention Services for HIV (for "Designated States" Only)**

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?  Yes  No
2. Are you considering any of the following:
  - a) Establishment of EIS-HIV service hubs in rural areas  Yes  No
  - b) Establishment or expansion of tele-health and social media support services  Yes  No
  - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  Yes  No

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C. 300x-31(a)(1)F)?  Yes  No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle  Yes  No

Exchange) Program?

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

Yes  No

If yes, please provide a brief description of the elements and the arrangement

**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement  Yes  No
2. Are you considering any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of service for:
    - i) MAT  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Are you considering any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)  Yes  No
2. Are you considering any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) Develop an organized referral system to identify alternative providers  Yes  No
  - a) Develop a system to maintain a list of referrals made by religious organizations  Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Are you considering any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No
  - c) Identify workforce needs to expand service capabilities  Yes  No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

### Patient Records

1. Does your state have an agreement to ensure the protection of client records?  Yes  No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements  Yes  No
- b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
- c) Updating written procedures which regulate and control access to records  Yes  No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  Yes  No

### Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

50% of the agencies that are approved for services will be reviewed by the DMH Certification Department.

3. Are you considering any of the following:
- a) Development of a quality improvement plan  Yes  No
- b) Establishment of policies and procedures related to independent peer review  Yes  No
- c) Develop long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No

**If YES**, please identify the accreditation organization(s)

- i)  Commission on the Accreditation of Rehabilitation Facilities
- ii)  The Joint Commission
- iii)  Other (please specify)

The Mississippi Department of Mental Health Certification Department.

<http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf>

<http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf>

**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
2. Are you considering any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  Yes  No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  Yes  No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state  Yes  No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  Yes  No
  - c) Performance-based accountability  Yes  No
  - d) Data collection and reporting requirements  Yes  No
2. Are you considering any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs  Yes  No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services  Yes  No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  Yes  No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).*

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women  Yes  No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis  Yes  No
  - b) Early Intervention Services Regarding HIV  Yes  No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment  Yes  No
  - b) Professional Development  Yes  No
  - c) Coordination of Various Activities and Services  Yes  No

**Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.**

<http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf>

<http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf>

**Footnotes:**

## Environmental Factors and Plan

### 12. Quality Improvement Plan- Requested

#### Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

#### Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?  Yes  No

Does the state have any activities related to this section that you would like to highlight?

Overview for Quality Improvement

The Mississippi Department of Mental Health bases its administrative operations and service delivery on principles of continuous quality improvement. The CQI principles are evident in the agency's practices for initial and ongoing certification of provider agencies and its response to reportable events, including grievances and serious incidents. The Bureau of Quality Management, Operations and Standards (BQMOS) is responsible for the policies and practices related to certification and for managing the agency's grievance and serious incident management systems. BQMOS is also responsible for provider standards of care known as the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers ("DMH Operational Standards").

DMH Operational Standards address the following areas for providers of community services certified by DMH:

- Certification Requirements
- Organization and Management
- Quality Assurance
- Fiscal Management
- Human Resources
- Training/Staff Development
- Health and Safety
- Rights of People Receiving Services
- Serious Incidents
- Service Organization
- Individual Planning of Treatment, Services and Supports
- 55 Population Specific Services

At the state level, DMH utilizes a Quality Management Workgroup. The DMH Quality Management Workgroup is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to the Bureau of Quality Management, Operations and Standards. In order to provide status reports and make recommendations, the Quality Management Workgroup reviews data related to serious incidents, grievances, and deficiencies related to DMH monitoring visits to identify trends and patterns among the data sets. Additionally, the workgroup may review plans of compliance from DMH certified providers and make recommendations regarding needed quality improvement activities. Plans of Compliance from DMH certified provider agencies include the corrective action put in place to address specific issues, as well as plans for future compliance.

At the provider level, DMH requires that agencies put in place quality management strategies that address collection of performance measures, analysis of serious incidents, analysis of client level data, and oversight for the development and implementation of required plans of compliance.

At the state level, serious incidents and grievances are handled through the Office of Consumer Support within BQMOS. Both serious incidents and grievances are reviewed and assigned a level for DMH response and follow up. In response to both, providers are given the opportunity to implement corrective action and put quality improvement measures in place to prevent future occurrence of related events.

Please indicate areas of technical assistance needed related to this section.

**Footnotes:**

## Environmental Factors and Plan

### 13. Trauma - Requested

#### Narrative Question

**Trauma**<sup>60</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>61</sup> paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

#### Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?  Yes  No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

As required by the Department of Mental Health's Operational Standards, mental health providers certified by the Department of Mental Health have integrated trauma screening practices into the initial intake assessment process for individuals receiving services. All new cases must have a Trauma Screening with documentation in the case records of individuals receiving services.

The Department of Mental Health, Division of Children and Youth Services continues to provide trauma-informed trainings to community and state partners including family members and caregivers. Since 2006, providers of children and youth mental health services in Mississippi have been trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT). To date, there are 380 TF-CBT Therapists, 110 SPARCS Therapists and 15 CPC-TFC Therapists.

Mississippi also has (3) three National Child Traumatic Stress Network Sites. They are Catholic Charities, Inc., Region 13/Gulf Coast Mental Health Center, and Wilson-Sigrest, LLC. In direct response to the needs from Hurricane Katrina, Mississippi was the first State to have a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) state level Learning Collaborative coming out of National Child Traumatic Stress Network (NCTSN).

2014, the Department of Mental Health held its first state-wide Trauma Conference. In addition to cross system training on Trauma - Informed Care, DMH continues to partner with several state and local agencies to host the annual Mississippi Trauma Informed Care Conference. The 2017 Trauma Informed Care Conference will be held September 27-29, 2017. These annual conferences have brought together more than 600 participants each year. The sessions are inclusive and appropriate for a diverse audience representing mental health and substance abuse professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more.

Please indicate areas of technical assistance needed related to this section.

**Footnotes:**

# Environmental Factors and Plan

## 14. Criminal and Juvenile Justice - Requested

### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>62</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>63</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>62</sup> Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

<sup>63</sup> <http://csjusticecenter.org/mental-health/>

### Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?  Yes  No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?  Yes  No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?  Yes  No

5. Does the state have any activities related to this section that you would like to highlight?

In September, 2016, Mississippi was awarded a \$647,461 federal grant aimed at reducing recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. The Department of Corrections (MDOC) and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders for 36 months, beginning October 1, 2017. Region 9, Hinds Behavioral Health Services (HBHS), will be the provider for this pilot project.

Please indicate areas of technical assistance needed related to this section.

### Footnotes:

## Environmental Factors and Plan

### 15. Medication Assisted Treatment - Requested

#### Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?  Yes  No
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately\*?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?  
Medication Assisted Treatment (MAT)

In Mississippi, the implementation of MAT has been complex over the past few years. The state is largely rural but also has several areas with large population densities. In addition, the provider community has not received much exposure to the benefits of MAT until 2014 when the SSA strongly encouraged providers to begin dialog with their treatment facilities on the benefits of MAT. Also, BADS is currently receiving technical assistance in the form of a one-year learning collaborative designed to assist programs in implementing and sustaining MAT within their treatment facilities. To date, four programs are involved in the collaborative. Provider education includes webinars, live presentations, conference calls and on-site monitoring.

*Please indicate areas of technical assistance needed to this section.*

The Department of Mental Health, Bureau of Alcohol and Drug Services, is requesting technical assistance for expanding Medication Assisted Treatment in the state of Mississippi.

*\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

#### Footnotes:

# Environmental Factors and Plan

## 16. Crisis Services - Requested

### Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.<sup>64</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)<sup>65</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

<sup>64</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>65</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please respond to the following items:

#### 1. Crisis Prevention and Early Intervention

- a)  Wellness Recovery Action Plan (WRAP) Crisis Planning
- b)  Psychiatric Advance Directives
- c)  Family Engagement
- d)  Safety Planning
- e)  Peer-Operated Warm Lines
- f)  Peer-Run Crisis Respite Programs
- g)  Suicide Prevention

#### 2. Crisis Intervention/Stabilization

- a)  Assessment/Triage (Living Room Model)
- b)  Open Dialogue
- c)  Crisis Residential/Respite
- d)  Crisis Intervention Team/Law Enforcement
- e)  Mobile Crisis Outreach
- f)  Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### 3. Post Crisis Intervention/Support

- a)  WRAP Post-Crisis
- b)  Peer Support/Peer Bridgers
- c)  Follow-up Outreach and Support
- d)  Family-to-Family Engagement

- e)  Connection to care coordination and follow-up clinical care for individuals in crisis
- f)  Follow-up crisis engagement with families and involved community members
- g)  Recovery community coaches/peer recovery coaches
- h)  Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content varies based on each individual's needs but includes close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. The DMH funds seven, 16-bed CSUs and partially funds one, 24-bed CSU throughout the state.

Additionally, DMH provides funding to the 14 CMHCs to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC's regions. The calls received by the crisis phone line are triaged for severity. Some calls are handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team. Each CMHC region is required to provide mobile response services in every county they serve. The mobile crisis response teams (MCeRTS) must be able to respond within one hour in an urban area and within two hours in a rural area. The mobile crisis response teams are required to have a Master's level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity. Additionally, if the mobile crisis response team must respond in an area that may not be safe, law enforcement accompanies them. A strong working relationship with law enforcement is required through the grant funding. The mobile crisis response team triages during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with psychiatric care available. The mobile crisis response team develops working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The "warm-handoff" model is used to facilitate services for the person in crisis with the next provider. Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter "regular" services with the CMHC or other provider. All individuals receiving services at a CMHC who have recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMHC staff and any significant others the individual wants involved. As part of the crisis response system, the CMHC's develop a multi-disciplinary assessment and planning team (MAP Team) made up of all the agencies that work with the most well-known individuals in the community. The MAP teams usually consists of mental health, health, human services, police department, sheriff's office, chancery clerk, faith based ministries, housing, etc., to develop a plan for the individuals in their community which consume the most time from all these agencies. The MAP Teams work together to find an alternative to continually committing the same individuals over and over to one of the state behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff's Office to develop Crisis Intervention Teams (CIT) across the state. The Lauderdale Sheriff's Office is a training site for officers from anywhere in the state to come for the 40-hour training required to be a CIT officer. The local CMHC is fully involved in the curriculum development and presentation. The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions.

*Please indicate areas of technical assistance needed to this section.*

**Footnotes:**

## Environmental Factors and Plan

### 17. Recovery - Required

#### Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

**Recovery** is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- |   |  |  |
|---|--|--|
| • Clubhouses  | Peer-run respite services                  | Whole Health Action Management (WHAM)                              |
| • Drop-in centers                                     | • Peer-run crisis diversion services       | • Shared decision making   |
| • Recovery community centers                          | • Telephone recovery checkups              | • Person-centered planning   |
| • Peer specialist                                     | • Warm lines                               | • Self-care and wellness approaches                                |
| • Peer recovery coaching                              | • Self-directed care                       | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching                              | • Supportive housing models                | • Room and board when receiving treatment                          |
| • Peer health navigators                              | • Evidenced-based supported employment     |  |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) |  |
| • Peer-delivered motivational interviewing            |  |  |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

---

**Please respond to the following:**

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
- b) Required peer accreditation or certification?  Yes  No
- c) Block grant funding of recovery support services.  Yes  No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  
Individuals receiving services and/or family members are involved in planning (advisory councils, task forces and work groups), evaluation (members of DMH certification team and evaluating services/programs through personal outcome measures) and implementing (peers and/or family members are providing services as CPSS).

2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

DMH has adopted SAMSHA definition of Recovery. Recovery is defined as A process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential. SMI has a description of peer support services and I think A&D has recovery support services. According to DMH Operational Standards, "Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the individual. It may also be provided as a family partner role."

DMH has adopted SAMSHA 10 Components of Recovery and added 1 additional component Resiliency.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery

The Mississippi Department of Mental Health has adopted the philosophy that "all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented" as highlighted in the Mississippi Board of Mental Health and Mississippi Department of Mental Health Strategic Plan. The FY16 – FY18 DMH Strategic Plan includes objectives focused on utilizing peers and family members to provide varying supports to assist individuals in regaining control of their lives and their recovery progress. These objectives are met through the Certified Peer Support Specialist Program, recovery-oriented system of care trainings, Personal Outcome Measures (POM), and other activities. The Plan also includes strategies to increase the use of Wellness Recovery Action Plans (WRAP) and Whole Health Action Management (WHAM) at DMH's behavioral health programs. In 2014, DMH established a Division of Recovery and Resiliency within the Bureau of Outreach, Planning and Development. The Division administers the Certified Peer Support Specialist Program for people who have lived experience of mental illness and/or substance use disorder and/or family members who want to provide peer recovery services to others. The Division is responsible for implementing the Think Recovery awareness campaign and moving the public mental health system towards a recovery-oriented system of care.

The DMH Strategic Plan sets forth the DMH's vision of having individuals who receive services to have a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. Initiatives in the State Plan are designed to facilitate a system that is person-centered and built on the strengths of individuals and their families while meeting their needs for special services. The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 1 of the DMH Strategic Plan highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long term community supports and other specialized services.

Goal 1 of the Strategic Plan also provides a foundation on which the DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

Recovery means something different to everyone. DMH has adopted the following definition of recovery: Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery which DMH has also adopted:

- Health: overcoming or managing one's disease(s) or symptoms, for example: abstaining from use of alcohol, illicit drugs, and non-prescribed medication if one has an addiction problem; and for everyone in recovery, making informed health choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live:
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society, and
- Community: relationships and social networks that provide support, friendship, love and hope

#### Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. Efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health system include:

Planning Services – Consumers and family members have an opportunity for meaningful participation on planning councils, task forces and work groups on a state, local, and national level.

Delivery of Services – Consumers and family members are employed as certified peer support specialist and/or peer support specialist.

Evaluation of Services – Consumers and family members have an opportunity to participate on personal outcome measure interviews using the Council on Quality of Life Personal Outcome Measures. The personal outcome measure interviews provide an opportunity for consumers and family members, through a guided conversation, to evaluate quality of life. Consumers and Family members, on a local level are involved in consumer and family satisfaction surveys.

The DMH sponsors meetings with peer support specialists and certified peer support specialists to discuss the role of peer support and barriers to provision of peer support services within the behavioral health service system. The DMH also sponsors Mental Health Planning Councils and various task forces, work groups and committees as an avenue to address issues and needs regarding the behavioral health service system.

Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning; shared decision making; and direct their ongoing care through the Breakthrough Series. The DMH provides trainings to peer specialists and is working with advocacy groups, consumers and family members to develop a system that affords consumers and family members the opportunity for meaningful participation in treatment, service delivery system, etc.

Based on the 2014 Advisory Council Survey, individuals and family members are in leadership positions within our state planning councils. Specifically, the Chairperson of two of the state's four Planning Councils is either a family member or individual receiving services. As a result of the survey, DMH hosted a Leadership Academy in May to offer individualized training for 25 people to focus on how to expand their current role and serve on taskforces, workgroups, etc.

As part of the Department of Mental Health's continued efforts to maximize the involvement and participation of individuals/family members in service planning, the Division of Recovery and Resiliency hosted the 2015 Mississippi Leadership Academy. The Mississippi Leadership Academy training provides people in recovery with the competencies and skills to take leadership roles in their communities. The Mississippi Leadership Academy curriculum covers principles of advocacy, empowerment, leadership, communication, diversity, wellness and recovery. Previous graduates of the Academy have started support groups, obtained paid jobs as Certified Peer Support Specialists and become active on advisory councils, task forces, committees, and workgroups.

Involvement of individuals/family members on advisory councils, task forces, committees, and work groups is one means of providing opportunities for meaningful participation. This is congruent with DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Rule 8.1 (6), which states the governing board must have documentation of a "process for meaningful individual and family involvement in service planning, decision making, implementation and evaluation. Individuals should be provided the opportunity for meaningful participation in planning at least for their service area."

#### Housing

Included in the DMH Strategic Plan are several objectives and strategies for improving and expanding housing opportunities that will enable more individuals to be served effectively in fully integrated community living. During calendar year 2012, a significant DMH Strategic Plan benchmark was achieved with the establishment of a DMH Division of Housing and Community Living and appointed a full-time director of this new Division. In order to be successful in addressing housing needs of persons served, additional Strategic Plan objectives include increasing the percentage of funding allocation to housing as a priority service as well as seeking to provide a full array of supported housing services in communities throughout the state. In the FY16 – FY18 DMH Strategic Plan, the agency will focus on increasing the availability of community supports/services for people with SMI in order to

implement the Permanent Supportive Housing model.

In 2014, DMH contracted with the Technical Assistance Collaborative (TAC) to develop a statewide housing plan. Participants include DMH, DHS, DOM, Governor's Office, MDA, MS Home Corp., Department of Corrections, and Department of Health. The goal is to increase the number of safe, decent, affordable housing options that include a range of choices for Mississippians. In 2015, the State received funding for this project from the Mississippi State Legislature for Mississippi Home Corp.

In addition, the Cooperative Agreement to Benefit Homeless Individuals (CABHI), a federal, time-limited grant which began in December 2014, will address housing and support service needs of persons who are experiencing chronic homelessness who have a substance use or co-occurring use and mental health disorder. This will be accomplished by combining the provision of resources and services while supporting the dissemination of best practices statewide and incorporating recovery at every level of service. Over a three year period, a total of 297 individuals are expected to be enrolled and served, with outreach services provided to as many as 500 individuals. Included in this project is a commitment from five housing service providers in the state of approximately 109 housing slots per year, for a total of 327 housing slots.

The DMH realizes that in order for individuals served to live successfully in the community, a full array of supportive services needs to be developed and maintained. This is also addressed in the DMH Strategic Plan with an objective to provide community supports for persons transitioning to the community through participation in the Mississippi Division of Medicaid's Money Follows the Person (MFP) demonstration project. Within the scope of the MFP project, the DMH is actively implementing a plan to expand Medicaid-funded Waiver Services to enable individuals with IDD to transition from DMH residential programs to fully integrated community living. In conjunction with the expansion of Waiver Services, there is specific funding in MFP for specific, time-limited costs associated with helping individuals successfully transition to the community of their choice. Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program and to work with the transition team at each program.

#### Certified Peer Support Specialist Program

The DMH's Peer Support Specialist Program began in 2012. Since then, a total of 165 people have been trained and 140 are Certified Peer Support Specialists (CPSS). CPSSs are required to have 20 hours of continuing education. A CPSS is a family member and/or individual who has self-identified as having received or is presently receiving behavioral health services. Additionally, a CPSS has successfully completed formal training recognized by the DMH and is employed by a DMH Certified Provider. These individuals use their lived experience in combination with skills training to support peers and/or family members with similar experiences. CPSSs support their peers both individually and in groups. Under general supervision, a CPSS performs a wide range of tasks to assist individuals to regain control of their lives and their own recovery and resiliency journey. CPSSs provide varying supports, some of which might be offered by others in the behavioral health system, but CPSSs contribute something unique. They are living proof that recovery is possible. CPSSs share lived experiences and are willing to share their stories to benefit others. The DMH is also focused on a training program for family and parents of children with behavioral disorders defined as a Serious Emotional Disturbance (SED). Currently, there are six (6) CPSSs that identify as a parent or caregiver of a youth with SED. However, DMH and those CPSSs realize that a more specified training is needed for those family and parents who wish to work with families that are experiencing mental health challenges with their children. The DMH is working to develop a curriculum focusing on training for a Certified Parent/Caregiver Support Specialist.

The DMH contracts with eight CPSSs and one CPSS Supervisor, who serve as CPSS Ambassadors, to provide technical assistance to providers, to provide support to other CPSSs, and to conduct trainings across the state. DMH worked with the Ambassadors to create two toolkits – a CPSS Provider Toolkit (for providers interested in employing a CPSS or who want to learn more about how to utilize a CPSS) and a CPSS Toolkit (for individuals who are interested in becoming a CPSS). In collaboration with CPSS Ambassadors, DMH developed a PowerPoint based on the CPSS Provider Toolkit. The training targets the following: 1) Organizations who already employ CPSSs; 2) Organizations who have decided to employ CPSSs and would like to know how to introduce them successfully into the workplace; 3) Organizations thinking about employing CPSSs.

The DMH has monthly calls with CPSSs and Peer Support Specialists to look at employment opportunities, training opportunities, and other valuable information.

#### Personal Stories of Recovery

The DMH saw the need for people to share their own personal stories of recovery to help inspire both providers and other individuals on their road to recovery. DMH has filmed more than 25 videos of people sharing their stories. DMH also filmed two CPSSs talking about the benefits of employing CPSSs and two CPSS supervisors sharing the difference CPSSs have made in their organizations. All videos are on DMH's Web site and one video each highlighted monthly via e-mail. The DMH also partners with NAMI-MS to host a Share Your Story Workshop twice a year to provide tips on how to effectively tell your recovery story.

#### Drop-In Center

The Mental Health Association of South Mississippi Opal Smith Drop-In Center offers a day program for adults with mental illness and people with disabilities. Instead of being alone, people fill their day with arts, crafts and games, making friends, and gaining confidence. At the Center, they can explore personal interests in a safe, non-judgmental way and learn to become more independent in a recovery-oriented environment. The Center also develops Wellness Recovery Action Plan (WRAP) with people who come to the Center.

#### Supported Employment

The DMH has developed and made available supported employment services based on the Substance Abuse and Mental Health

Services Administration's Evidence-Based Practice for Supported Employment and Dartmouth Individual Placement and Supports Model (IPS). In 2015, DMH began implementation of this program with four pilot program sites operated through the Community Mental Health Centers in Region 2, Region 7, Region 10 and Region 12. These services are available for adults living with mental illness, and DMH will be collaborating with the Mississippi Department of Rehabilitation Services to leverage each agency's ability to provide employment supports.

#### Internal Training and Outreach

The DMH distributed an internal survey to Central Office staff to gauge their understanding of recovery. As a result of the survey, DMH employees at all levels within the agency participated in a mandatory training to provide a better understanding of the ongoing transition to a recovery-oriented system of care. DMH's newly established Division of Recovery and Resiliency led the training sessions, but they did so with the help of the CPSS Ambassadors. CPSSs shared how they have been directly impacted by their own or their loved ones' struggle with mental illness. They walked DMH staff through each of the Components of Recovery. DMH staff marveled at their presentation skills and their courage to share personal information in order to help all employees understand the need and value in continuing to move toward a recovery-oriented system of care.

DMH and CPSS Ambassadors offer a variety of technical assistance and trainings to DMH Certified Providers about recovery principles and practices in addition to the role of peer support specialists.

**5. Does the state have any activities that it would like to highlight?**

Think Recovery Videos

CPSS Parent/Caregiver Designation

CPSS integration onto DMH Certification Process

Employment-Related Certification

CPSS Training and multiple training opportunities throughout the year

Train the Trainer Program for CPSS

Please indicate areas of technical assistance needed related to this section.

The State of Mississippi is not requesting technical assistance in this area at this time.

**Footnotes:**

## Environmental Factors and Plan

### 18. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

#### Please respond to the following items

- Does the state's Olmstead plan include :
  - housing services provided.  Yes  No
  - home and community based services.  Yes  No
  - peer support services.  Yes  No
  - employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The CHOICE program described below, the eight (8) Programs of Assertive Community Treatment (PACT) teams, and Personal Outcome Measures (POM) interviews are addressing the ADA community mandate required by the Olmstead Decision in our state.

Does the state have any activities related to this section that you would like to highlight?

In June 2013, the Department of Mental Health facilitated a SAMHSA-sponsored Olmstead Policy Academy to help Mississippi develop action plans to increase community integration for people with behavioral health issues. With the help of a lead facilitator assigned to us by SAMHSA, a Mississippi team spent several months developing a one-year action plan with goals and strategies to help us promote community integration through improved housing, employment, and recovery support opportunities for people with behavioral health disorders in Mississippi. The team was made up of approximately 30 individuals representing service providers, policy makers, and stakeholders in the targeted areas of housing, employment, and recovery support. The Olmstead Policy Academy Strategic Plan that resulted from the efforts of the Policy Academy members identified goals, strategies, and activities for each of the three critical areas included in the plan that ultimately led to the development in 2014 of a more comprehensive, targeted state plan for statewide systematic approach to addressing the requirements of Olmstead and Title II of the ADA.

Multiple agencies, including development authorities, housing corporations, regional housing authorities, state departments, federally funded contractors and local contracted providers have a role in providing housing and supportive services for individuals with disabilities and life challenges in the State of Mississippi. In 2014, the State of Mississippi, through an appropriation to the Mississippi Department of Mental Health (DMH), engaged in the development at a statewide integrated, supportive housing (ISH) strategy for people with mental illness, intellectual and developmental disabilities (IDD), addictive disease, Veterans and other high need populations in Mississippi served by agencies such as the Department of Human Services (DHS), Department of Health (DOH), and the Department of Corrections (DOC). ISH refers to safe, secure and affordable housing, where tenancy is not time-limited as long as the resident pays the rent and honors the conditions of the lease. Individualized and

flexible support services are available to residents based upon their choices and needs.

The Creating Housing Options in Communities for Everyone (CHOICE) program, funded by the State of Mississippi, is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and the 14 community mental health centers. The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance, with supportive mental health services through Integrated Supportive Housing. The goals of the CHOICE program are to assist individuals with mental illness or disabilities with permanent housing, peer services and community-based services, make 2,500 rental units available for the target population within five (5) years, connect CHOICE participants to available resources through an integrated referral process, and help CHOICE participants obtain and retain permanent housing in the community. CHOICE participants are assisted by priority. Priority 1 individuals are those that are being discharged from a state psychiatric hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities after a stay of more than ninety (90) days. Priority 2 individuals are those who have been discharged from a state psychiatric hospital within the last two (2) years and have had multiple hospital visits within the last year due to mental illness, are known to the mental health or state housing agency to have been arrested or incarcerated in the last year due to conduct related to mental illness or who are known to have been homeless for one (1) full year or have had four (4) episodes of homelessness in the last three (3) years. Priority 3 individuals are those who lack a fixed, regular, and adequate nighttime residence and/or who are exiting from an institution where they resided for ninety (90) days or less and who resided in emergency shelters or places not meant for human habitation immediately before entering that situation. There have been approximately 130 individuals housed through the CHOICE program since March 2016.

During Mississippi's Legislative session that ended in April 2015, a bill was passed and signed by the Governor to fund a State Bridge Subsidy voucher targeted to individuals identified in Olmstead and included in a joint agreement letter dated August 29, 2014, between the US Department of Justice and the Attorney General of Mississippi. Implementation of the state-funded bridge subsidy program is administered by the MS Home Corporation (MHC) which is Mississippi's Housing Finance Agency in direct partnership with the Department of Mental Health and with active participation by the state's Community Mental Health Centers (CMHC).

Please indicate areas of technical assistance needed related to this section.

**Footnotes:**

## Environmental Factors and Plan

### 19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

#### Narrative Question

---

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community<sup>66</sup>. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24<sup>67</sup>. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death<sup>68</sup>.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21<sup>69</sup>. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs<sup>70</sup>.

According to data from the 2015 Report to Congress<sup>71</sup> on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

<sup>66</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>67</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>68</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>69</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>70</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

<sup>71</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult behavioral health system?  Yes  No
  - for youth in foster care?  Yes  No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

DMH was recently awarded a Cooperative Agreement to begin October 1, 2017, which will focus on youth who are involved with the child welfare and/or juvenile justice systems, referred to as "crossover youth". The Crossover XPand SOC project will expand current and graduated System of Care (SOC) programs in two jurisdictions served by Region 12/Pine Belt Mental Healthcare Resources and Region 10/Weems Community Mental Health by prioritizing crossover youth and their families and those at risk of becoming crossover youth or underserved children and youth who are involved in the child welfare/advocacy system and/or the juvenile justice system. The priority children and youth will have a diagnosed serious emotional disorder (SED), co-occurring disorder (COD), or first episode of psychosis (FEP), be ages 3 -21, reside in Forrest, Jones, Lauderdale, or Marion Counties in Mississippi, and be involved with child protection services and/or juvenile justice, or be at risk for involvement.

The goals of Crossover XPand SOC are: 1) to expand Mississippi's SOC by targeting at risk and crossover youth (ages 3-21) with SED/COD/FEP and their families and expanding integrated care with evidence-based interventions; 2) to increase awareness of, and community commitment to, the mental health issues of at risk and crossover youth; 3) to improve organizational and systemic capacity to serve at risk and crossover youth with SED/COD/FEP across five levels of care; 4) to expand youth and family roles as full and equal partners within an integrated system of care; and 5) to use continuous quality improvement to drive and sustain effective service delivery for replication. Crossover XPand SOC will annually engage a minimum of 100 at risk or crossover youth, for a total of 400 youth over the entire project period. Other objectives include improving time to engage youth by integrating

services at strategic intercept points, expanding access to care, and creating a skilled trauma-focused workforce.

Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need. The DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide.

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

**Footnotes:**

# Environmental Factors and Plan

## Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2018

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dewitt Bean	Others (Not State employees or providers)		606 Bean Road Iuka MS, 38852 PH: 662-423-6819	dbib@att.net
William ( Bubba) Bland	State Employees		246 Moores Creek Road Maben MS, 39750 PH: 601-954-1966	Bland_willams@ago.state.ms.us
Mark Chaney	Others (Not State employees or providers)		7070 Hwy 80 Vicksburg MS, 39180 PH: 601-638-4784	katchaney@bellsouth.net
Dr. Shawn Clark	State Employees		5234 Parkway Drive Jackson MS, 39211 PH: 601-957-6746	shawn.clark@va.gov
Joseph Craft	State Employees		114 Concord Drive Clinton MS, 39056 PH: 601-259-8747	jcrafft@courts.ms.gov
Dana Crenshaw	State Employees		6360 I-55North 400 Jackson MS, 39211	dcrenshaw@mbp.state.ms.us
Carol Elrod	State Employees		P. O. Box 1698 Jackson MS, 39215	celrod@mdrs.ms.gov
Lit Evans	Others (Not State employees or providers)		816 Cross Street Cleveland MS, 38732 PH: 662-843-4741	
Dr. Kevin Freeman	Providers		2500 North State Street Jackson MS, 39216	kfreeman@umc.edu
Bruce Gibson	Others (Not State employees or providers)		306 26th Avenue Meridian MS, 39301 PH: 601-482-0913	gibson@live.com
Joe Grist	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1937 Briar Ridge Road Tupelo MS, 38804 PH: 662-690-4200	joe_grist@nmsh.state.ms.us
Russell Hanna	State Employees		P. O. Box 540 Madison MS, 39110	rusty.hanna@dor.ms.gov
Rodney Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5234 Parkway Drive Jackson MS, 39211	ronney.henderson@va.gov
Martha Lynn Johnson	Providers		1058 Good Hope Road Batesville MS, 38606 PH: 662-563-9250	

Michael Jordan	State Employees		239 North Lamar Jackson MS, 39201	michael.jordan@dmh.ms.gov
Paul Matens	Others (Not State employees or providers)		219 Cambridge Drive Madison MS, 39110 PH: 601-898-6057	paulmatensoo@comcast.net
Jerry McClendon	State Employees		3794 Pearl MS, 39208 PH: 601-359-3499	jmccclendon@mdoc.state.ms.us
Sandra Moffett	Others (Not State employees or providers)		1025 North Park Drive Ridgeland MS, 39157 PH: 601-977-3728	smoffett@aol.com
Curtis Oliver	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		610 South Washington Brookhaven MS, 39601 PH: 601-455-7488	Nana41056@gmail.com
Ekoko Onema	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3450 US 80 Jackson MS, 39209	ekokomonique@gmail.com
Pamela Smith	State Employees		239 North Lamar Jackson MS, 39201	pamela.smith@dmh.ms.gov
Bettye Tate-McAfee	Federally Recognized Tribe Representatives		210 Hospital Circle Philadelphia MS, 39350 PH: 601-389-6291	btategardner@choctaw.org
DeGarette Tureaud	State Employees		805 S Whatley Street Ridgeland MS, 39157 PH: 601-991-6050	Degarrette.turead@msdh.state.ms.us
Melody Winston	State Employees		239 North Lamar Jackson MS, 39201 PH: 601-359-5198	melody.winston@dmh.ms.gov

**Footnotes:**

# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2018

Type of Membership	Number	Percentage
<b>Total Membership</b>	<b>23</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	6	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>10</b>	<b>43.48%</b>
State Employees	11	
Providers	2	
Vacancies		
<b>Total State Employees &amp; Providers</b>	<b>13</b>	<b>56.52%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>0</b>	
Persons in recovery from or providing treatment for or advocating for substance abuse services		
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

**Footnotes:**

# Environmental Factors and Plan

## 24. Public Comment on the State Plan - Required

Narrative Question

**Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)** requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
  - a) Public meetings or hearings?  Yes  No
  - b) Posting of the plan on the web for public comment?  Yes  No  
If yes, provide URL:  
<http://www.dmh.ms.gov/wp-content/uploads/2017/10/2017-2019-DMH-BADS-Approved-State-Plan-.pdf>
  - c) Other (e.g. public service announcements, print media)  Yes  No

**Footnotes:**