MISSISSIPPI DEPARTMENT OF MENTAL HEALTH BUREAU OF ALCOHOL AND DRUG SERVICES DRAFT FY 2017 – 2019 STATE PLAN

Supporting a Better Tomorrow...Today

DMH

Mississippi Department of Mental Health

Prevention Works.
Treatment is Effective.
People Recover.

Department of Mental Health

Bureau of Alcohol and Drug Services

STATE PLAN

FY 2017-2019

Presented by:

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Program Administrator

Melody Winston, M.S.,
Bureau Director

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Table of Contents

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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 atjake.hutchins@dmh.state.ms.us.

Sincerely,

Phil Bryant
GOVERNOR

STATE OF MISSISSIPPI • OFFICE OF THE GOVERNOR
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www.governorbryant .com

Mississippi Department of Mental Health

MISSION STATEMENT

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance use problems and intellectual/developmental disabilities one person at a time.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH VISION STATEMENT

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

A better tomorrow exists when…

- All Mississippians have equal access to quality mental health care, services, and supports in their communities.
- People actively participate in designing services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance use, and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

Bureau of Alcohol and Drug Services

Mission Statement

The mission of the Bureau of Alcohol and Drug Services is to provide quality care within a continuum of accessible community-based services including prevention, treatment, and recovery support in an effort to improve the health and well-being of all Mississippi citizens.

Vision Statement

In support of the mission, the Bureau of Alcohol and Drug Services will promote the highest standards of practice and the continuing development of substance use disorder programs and services related to current community needs.

Core Values and Guiding Principles of the Department of Mental Health

People: We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice, and provision of services to meet their unique needs.

Community: We believe the community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

Commitment: We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

Excellence: We believe services and supports must be provided in an ethical manner, 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, families, and service providers. Through open communication, we continuously build relationships.

Integrity: We believe the public mental health system should act in an ethical and trustworthy manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

Awareness: We believe awareness, education, prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

Innovation: We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

Respect: We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the mental health system.

Overview of the State Mental Health System

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 state-wide 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 this 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 online 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.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS	
Region 1: Coahoma, Quitman, Tallahatchie, Tunica	Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267
Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	LIFECORE Health Group Ricardo Fraga, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Timber Hills Mental Health Services Jason Ramey, Interim Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower	Life Help Phaedre Cole, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211
Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston	Community Counseling Services Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347
Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)
Region 9: Hinds	Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director

	3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	Southwest MS Mental Health Complex Sherlene Vince, Executive Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Shelley Foreman, LPC, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Mental Health Services Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Available Services and Supports

Both facility and community-based services and supports are available through DMH service system. The type of services provided depends on the location and provider.

Behavioral Health Services

The types of services offered through the regional behavioral health programs vary according to location but include:

Acute Psychiatric Care
Psychiatric Care
Continued Treatment Services
Adolescent Services
Community Service Programs
Nursing Home Service Intermediate
Medical/Surgical Hospital Services
Forensic Services
Substance Use Disorder Services

The types of services offered through the programs for individuals with intellectual/ developmental disabilities vary according to location but statewide include:

ICF/MR Residential Services
Psychological Services
Social Services
Medical/Nursing Services
Diagnostic and Evaluation Services
Special Education
Recreation
Speech/Occupational/Physical Therapy
Vocational Training/Employment
Community Services Programs

Community Services

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

Services for Adults with Mental Illness

Psychosocial Rehabilitation
Consultation and Education Services
Co-Occurring Disorder Services
Inpatient Referral Services
Intensive Residential Treatment
Supervised Housing
Physician/Psychiatric Services
SMI Homeless Services
Mental Illness Management Services
Individual Therapeutic Support
Crisis Emergency Mental Health Services
Pre-Evaluation Screening/Civil Commitment Exams
Halfway House Services
Group Home Services
Partial Hospitalization
Elderly Psychosocial Rehabilitation
Outpatient Therapy
Consumer Support Services
Day Support
Drop-In Centers
Crisis Stabilization Programs
Individual/Family Education and Support

Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Homes
Foster Care
Prevention/Early Intervention
Crisis/Emergency Mental Health Services
Response Services
Intensive Crisis Intervention Services
Consumer Support Services
Family Education and Support
Day Treatment Therapeutic
Outpatient Therapy
Physician/Psychiatric Services
MAP (Making A Plan) Teams Mobile Crisis
School Based Services
Mental Illness Management Services
Individual Therapeutic Support
Acute Partial Hospitalization

Services for People with Alzheimer's disease and Other Dementia

Adult Day Centers
Caregiver Training

Services for People with Intellectual/Developmental Disabilities

Early Intervention
Work Activity Services
Day Support
HCBS Behavioral Support/Intervention
HCBS In-home Nursing Respite
HCBS Day Habilitation
HCBS Occupational, Physical, and Speech/Languages Therapies
Community Living Programs
Supported Employment Services
HCBS Attendant Care
HCBS Community Respite
HCBS ICF/MR Respite
HCBS Support Coordination

Services for Individuals with Substance Use Disorders

Withdrawal Management
General Outpatient Services
Prevention Services
Recovery Support Services
Opioid Treatment Services
Co-Occurring Disorder Services
DUI Diagnostic Assessment Services
Intensive Outpatient Services
Primary Residential Services
Recovery Housing Services
Transitional Residential Services

SUBSTANCE USE DISORDER SERVICES

Contact Information

Region I: **Coahoma, Quitman, Tallahatchie, and Tunica** **http://www.regionone.org**	**Community Mental Health Center** **Shane Garrard, Director, Alcohol & Drug Services** **1742 Cheryl Street** **P.O. Box 1046** **Clarksdale , MS 38614** **(662) 624-4905 or 624-2152**
Region II: **Calhoun, Lafayette, Marshall, Panola, Tate, and Yalobusha** **http://www.communicarems.org/index.html**	**Communicare** **Melody Madaris, Director, Alcohol & Drug Services** **152 Highway 7 South** **Oxford, MS 38655** **(662) 234-7521**
Region III: **Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, and Union** **http://famecreative.com/lifecore**	**Lifecore Health Group** **Amanda Wilson, Director, Alcohol & Drug Services** **499 Gloster Creek Village, Suite A3** **Tupelo, MS 38801** **(662) 987-4261**
Region IV: **Alcorn, DeSoto, Prentiss, Tippah, and Tishomingo** **http://www.regionivmhs.com**	**Region IV Mental Health Services** **Nikki Tapp, Director, Alcohol & Drug Services** **303 North Madison Street** **P.O. Box 839** **Corinth, MS 38835-0839** **(662) 286-9883**
Region VI: **Attala, Bolivar, Carroll, Grenada, Holmes, Humphreys, Issaquena, Leflore, Montgomery, Sharkey, Sunflower, and Washington** **http://www.region6-lifehelp.org**	**Life Help** **Director, Alcohol & Drug Services** **254 Browning Road** **P.O. Box 1505** **Greenwood, MS 38935-1505** **(662)453-6211**

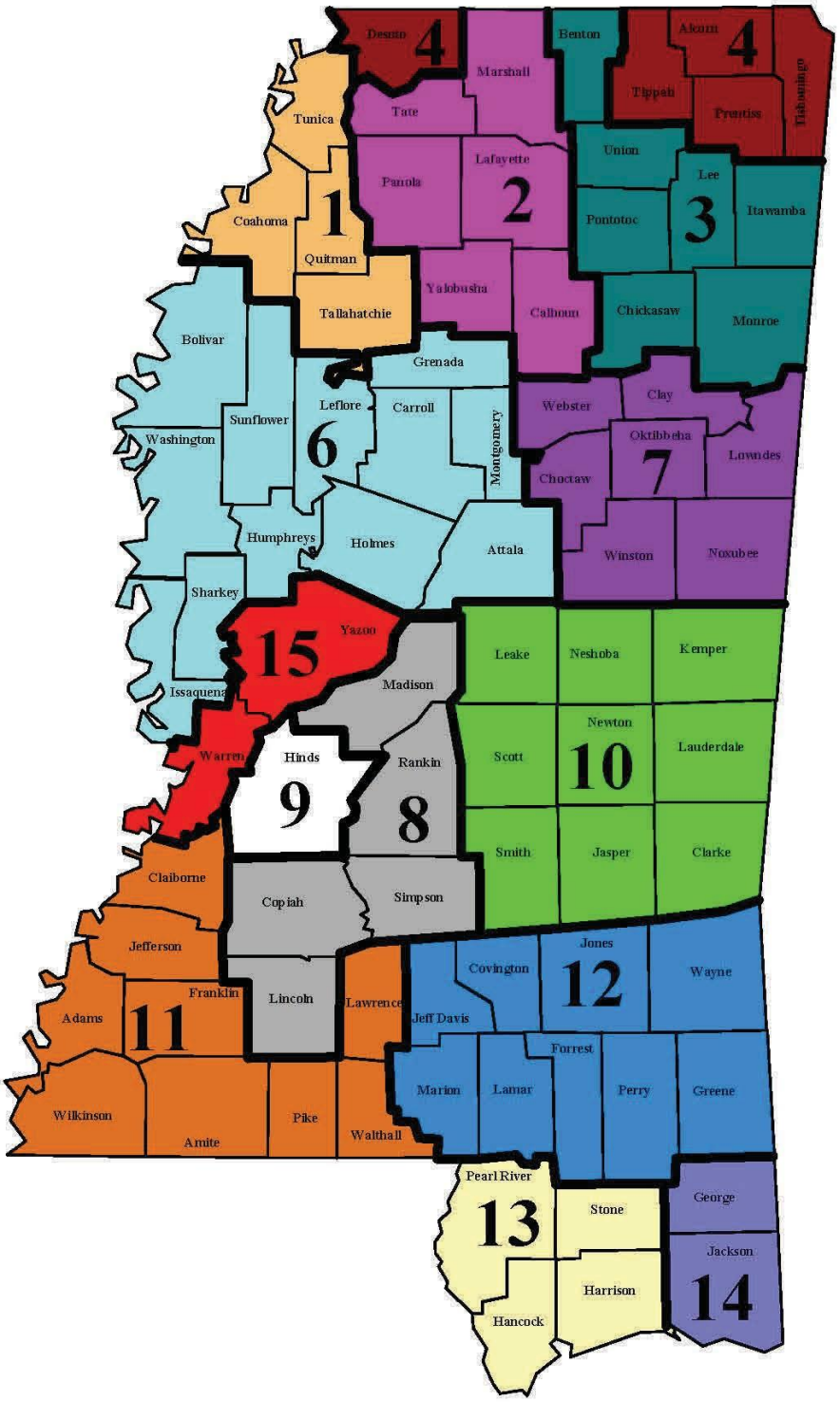
Region VII: **Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, and Winston** **http://www.ccsms.org**	**Community Counseling Services** **Lori Latham, Director, Alcohol & Drug Services** **1001 Main Street** **Columbus, MS 39701** **(662) 326-7916**
Region VIII: **Copiah, Lincoln, Madison, Rankin, and Simpson** **http://www.region8mhs.org**	**Region VIII Mental Health Services** **Stephanie Berry, Director, Alcohol & Drug Services** **613 Marquette Road, Box 88** **Brandon, MS 39043** **(601) 591-5553**
Region IX: **Hinds** **http://www.hbhs9.com**	**Hinds Behavioral Health Services** **Chan Willis, Coordinator, Alcohol & Drug Services** **3450 Highway 80 West** **P.O. Box 7777** **Jackson, MS 39284** **(601) 321-2400**
Region X: **Clarke, Jasper, Kemper, Lauderdale, Leake,** **Neshoba, Newton, Scott, and Smith** **http://www.weemsmh.com**	**Weems Community Mental Health Center** **Russ Andreacchio, Director, Alcohol & Drug Services** **1415 College Drive, Box 4378** **Meridian, MS 39325** **(601) 483-4821**
Region XI: **Adams, Amite, Claiborne, Franklin, Jefferson,** **Lawrence, Pike, Walthall, Wilkinson** **http://www.swmmhc.org**	**Southwest MS Mental Health Complex** **Director, Alcohol & Drug Services** **1701 White Street, Box 768** **McComb, MS 39649** **(601) 684-2173**

SUBSTANCE USE DISORDER SERVICES

Contact Information

Region XII: **Covington, Forrest, Greene, Jeff Davis, Jones,** **Lamar, Marion, Perry, Wayne** **http://pbmhr.com**	**Pine Belt Mental Healthcare Resources** **Carol Brown, Director, Alcohol & Drug Services** **103 S. 19th Ave., Box 18678** **Hattiesburg, MS 39403** **(601) 594-1499**
Region XIII: **Hancock, Harrison, Pearl River, and Stone** **http://www.gcmhc.com**	**Gulf Coast Mental Health Center** **Lisa Crain-Kersanac, Director, Alcohol & Drug Services** **1600 Broad Ave.** **Gulfport, MS 39501** **(228) 248-0125**
Region XIV: **George and Jackson** **http://www.singingriverservices.com**	**Singing River Services** **Sarah Pradillo, Director, Alcohol & Drug Services** **3407 Shamrock Ct.** **Gautier, MS 39553 (228)** **497-0690 X 2005 (866)** **497-0690**
Region XV: **Warren and Yazoo** **http://www.warren-yazoo.org**	**Warren-Yazoo Mental Health Services** **Peter Anderson, Director, Alcohol & Drug Services** **3444 Wisconsin Ave.** **Vicksburg, MS 39180** **(601) 634-0181**

Community
Mental Health/Intellectual Disability Center
Service Areas



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Regional Community-Based Primary Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Tutwiler	Fairland Center	Region I: Community Mental Health Center	24 12- Male 12-Female
Oxford	Haven House	Region II: Communicare	32 22-Male 10-Female
Tupelo	Region III: CDC	Region III: Lifecore	16 10- Male 6-Female
Corinth	Region IV: CDC	Region IV: Timber Hills Mental Health Services	24 12- Male 12-Female
Greenwood	Denton House CDC	Region VI: Life Help	44 32- Male 12-Female
Columbus	Cady Hill, The Pines	Region VII: Community Counseling Services	28 10- Male 18-Female
Hazlehurst	Female Residential	Region VIII: Mental Health Services Treatment Center	11 11-Female
Mendenhall	Male Residential	Region VIII: Mental Health Services Treatment Center	20 20- Male
Meridian	Weems Life Care	Region X: Weems Community Mental Health Center	27 22- Male 5-Female
Moselle	Clearview Recovery	Region XII: Pine Belt Healthcare Resources	27 20-Male 7-Female
Gulfport	Crossroads Recovery Center	Region XIII: Gulf Coast Mental Health	42 24 Male 18-Female

Pascagoula	Stevens Center	Region XIV: Singing River Services	18 6- Male 12-Female
Vicksburg	Warren-Yazoo CDC	Region XV: Warren Yazoo Mental Health	25 19- Male 6-Female
			Total Bed Capacity: 338

Free Standing Primary Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Jackson	Born Free	Catholic Charities	8 8-Female
Jackson	Harbor House	Harbor House of Jackson	46 26-Male 20-Female
Jackson	The Friendship Connection	Center for Independent Learning	12 12-Female
Columbus	Recovery House	Recovery House	6 6-Female
Southhaven	Turning Point	Freedom Healthcare	66 36- Male 18-Female 12-Either
			Total Bed Capacity: 138

Community-Based Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Tutweiler	Fairland Center	Region 1: Community Mental Health Center	8 4- Male 4-Female
Oxford	Haven House	Region II: Communicare	16 14-Male 2-Female
Tupelo	Region III CDC	Region III: Life Core	38 24-Male 14-Female
Corinth	Region IV CDC	Region IV: MH/MR	12 8-Female 4- Male
Greenville	Gloria Darden Center	Region VI: Life Help	36 24- Male 12-Female
Columbus	Cady Hill	Region VII: Community Counseling Services	16 10-Male 6-Female
Meridian	Alexander House	Region X: Weems Community Services	17 8-Male 8-Female 1-Either
Moselle	Clearview Recovery	Region XII: Pine Belt Healthcare Resources	27 20-Male 7-Female
Pascagoula	Stevens Center	Region XIV: Singing River Services	10 5-Male 5-Female
Vicksburg	Warren Yazoo CD	Region XV: Warren Yazoo Mental Health	25 20-Male 5-Female
			Total Bed Capacity: 205

Free-Standing Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Jackson	Harbor House of Jackson	Harbor House of Jackson	33 12- Male 21-Female
Jackson	New Beginnings	Catholic Charities	8 8-Female
Jackson	Friendship Connection	Center for Independent Learning	12 12-Female
Columbus	Recovery House	Recovery House Inc.	6 6-Female
			Total Bed Capacity: 59

Community-Based Primary Residential Substance Use Disorders – Adolescent Programs

Location	Program	Agency	Bed Capacity
Clarksdale	Sunflower Landing	Region 1: CMHC	32 16- Male 16-Female
			Total Bed Capacity: 32

Correctional-Based Primary Residential / Transitional Substance Use Disorders –

Adult Programs

Location	Program	Agency	Bed Capacity
Cleveland	Alcohol and Drug	Bolivar County Correctional Facility	76 76- Male
			Total Bed Capacity: 76

PREVENTION SERVICES

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

Most substance 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 disease 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 pre- pared 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 amount 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.

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. Staff attends the MS United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings. The DMH continues to receive technical assistance in the implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program in Mississippi as provided by SAMHSA. The purpose of SOAR is to help states increase access to mainstream benefits for individuals who are homeless or at risk for homelessness through specialized training, technical assistance, and strategic planning for staff that provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process. The DMH provides information and oversight regarding the online training. There is an online SOAR data collection system that SOAR processors in the state are encouraged to use to report the results of the SSI/SSDI applications that are submitted using SOAR.

POPULATION SERVED BY THE SYSTEM

Mississippi has the 32nd largest population among US states and territories. The U.S. Census Bureau figures estimated Mississippi's 2016 population at 2,988,726. Mississippi has 82 counties and 297 incorporated cities, towns and villages. Statistics reveal that over 50.1% of the state's population lives in rural areas since many of these incorporated are nevertheless rural. The Census reveals that Mississippi's population is 59.3% Caucasian and 37.7% African American, 0.6% American Indian, 1.1% Asian, 0.1% Native Hawaiian, and 3.1% Hispanics. The percentage of population under the age of 5 is reported at 6.3%, and the percentage of population under the age of 18 is 24.1%, and 15.1% over the age of 65. Approximately 76% of Mississippians are 18 years or older. Mississippi has one American Indian tribe that the federal government acknowledges, the Mississippi Band of Choctaw Indians. It has over 10,000 tribal members and half of their population is under the age of 25. Majority of Mississippians speak English primarily, 96.1%. Spanish is primarily language used by 2.4% of Mississippians and the remaining 1.5% of Mississippians uses other languages. The Bureau of Alcohol and Drug Services targets adolescents (17 and under), young adults (18—25), and adults (26 and older) by providing prevention and treatment intervention to combat the increase in licit and illicit substance use.

Age of Mississippians in 2016		
Age group	Number of Mississippians	Percentage of MS Population
Under 18	721,288	24.1%
18 to 24	295,917	9.9%
25 to 44	759,788	25.4%
45 to 64	760,792	25.5%
65 to 84	399,977	13.4%
85 & older	50,964	1.7%

Table 1: The number of Mississippians per age group and the percentage of the Mississippi population each age group represents are displayed (American Community Survey, 2016).

The U.S. Census Bureau indicated that in 2015, 22% of Mississippi families lived below the poverty level and the median household income was estimated at $39,665 compared to $53,889 nationally. Eight out of ten Mississippians have health insurance and over half of those insured have private health insurance. The number of Mississippians uninsured, 15.8%, is nearly double that of the national uninsured rate, 8.6%. High school graduates account for 82.3% of the population in the state while 20.7% hold a bachelor's degree or higher. Mississippi is one of the best states in the U.S. to do business. In fact, Mississippi has a diverse economy with a growing footprint in industries. Small business remains the backbone of the economy. The MS Development Authority (MDA) makes it a priority to help small business owners compete successfully in the marketplace. Industrial, commercial and consumer goods are all produced in our state. Mississippi made products are shipped to other countries regularly.

Mississippi has 3,484 homosexual couples and 58% of these couples are women in relationships. Homosexual Mississippians are six years younger than their heterosexual counterparts; individuals between the ages of 30 – 49 have the highest number of same-sex couples, at 54%, followed by 50–64 year olds with 29%. Majority of same-sex couples are Caucasians, 68.7%, and one in four same-sex couples are African American, followed by Latinos at 4.5%. Nearly one-third of same-sex Mississippians are care-givers to minors in their homes and 63% of those minors are biological children. One-third of same-sex couples that are raising minors are in a minority racial/ethnic group and approximately one in four are white. The median income of same-sex couples is $66,775, which is lower than heterosexual married couples.

Service Population

In general, activities to estimate/determine and monitor needs for substance use disorders services can be divided into two categories: (1) estimation of the number of persons with alcohol and/or drug problems and at risk for needing services; and (2) estimation or determination of needs for specific services among persons with alcohol and/or drug problems and among subgroups of the population. To gather comprehensive information about the prevalence of substance use disorder problems among the general population and among subgroups of the population, as well as more

detailed information on service needs and demand, the Bureau of Alcohol and Drug Services has collected data from multiple sources.

Substance Use Disorder Data Collection

There are a sizeable number of individuals in Mississippi at any given time which needs substance use disorder treatment services. The Division of Information Systems collects data regarding admissions, discharges, types of services provided, and the number of individuals served.

DataGadget

DataGadget is an online data portal that permits the state of Mississippi to track processes and outcomes associated with state-funded substance use disorders prevention and treatment programs. Through DataGadget, programs are required to report data on types of prevention services provided and clients served, the duration of service programs and outcomes associated with prevention. DataGadget is also utilized to track outcomes associated with substance use disorders treatment programs implemented throughout Mississippi. DataGadget facilitates the centralized tracking of activities and outcomes associated with Mississippi's funding of prevention and treatment programs. DataGadget enhances accountability between the state and regional programs and allows the Bureau of Alcohol and Drug Services to engage in data-driven planning and promote and increase evidence-based programming.

Mississippi Department of Education and Mississippi Private Schools

The Mississippi Department of Education reported 482,446 youth attended public schools in 2016-2017 and according to surveillance data on private schools in Mississippi, 57,114 youth attended private schools. These numbers do not include youth who are home-schooled, in detention centers, treatment centers, or hospitals. Many of these youth are at risk for substance use/abuse and in need of treatment due to peer pressure, easy access to drugs, and an increase in the advertising industry. The Mississippi Department of Education is instrumental in conducting the Youth Risk Behavior Survey to gather data on middle and high school students.

Mississippi's 2015 Youth Risk Behavior Surveillance System Survey (YRBS)

The Mississippi YRBS survey measures the prevalence of behaviors that contribute to the leading causes of mortality and morbidity among youth. The YRBS is part of a larger effort to help communities' promote the "resiliency" of young people by reducing high risk behaviors and increasing health behaviors. The Centers for Disease Control and Prevention's (CDC) Office on Smoking and Health developed the survey. The CDC provides technical assistance to the MS State Department of Health (MSDH) to administer the survey. The MSDH collaborates with the MS Department of Education to administer the survey in schools. The MSDH is responsible for all analyses associated with the survey. The YRBS was completed by students in high school, grades 9-12 during the spring of 2015. The YRBS is conducted every two years.

SmartTrack

The SmartTrack Survey is a web-based data collection tool which provides needs assessment data related to the Center for Substance Abuse Prevention core measures. It collects data on severity of substance use, risk and protective factors and identification of the most pressing prevention issues. The

data is collected from schools in communities throughout the state with the goal being to establish base-line data on prevalence and severity of substance use, as well as related behaviors and attitudes. A survey of 81,393 6th-11th grade public school students conducted during the 2015-2016 school term reveals the following protective factors among MS youth. Approximately 49% of students indicated that smoking marijuana regularly posed a great or moderate risk. Additionally, 56% of students stated that consuming four to five alcoholic beverages per day posed a great or moderate risk. Approximately 30% of surveyed students felt that they belonged to their school; 35% strongly felt that they belonged to their school com- pared to 8% that strongly disagreed. Approximately 54% of students stated that they never have major fights or arguments with their parent/guardian(s), while 81% indicated that they could ask their parents for help in dealing with a personal problem. Finally, 79% of students indicated that their parents always or frequently enforce rules at home.

Alcohol

According to the SmartTrack Survey, the percentage of students who had at least one alcoholic beverage in the past 30 days decreased from 19% in 2013 to 13.8% in 2016. The percentage of students who reported having at least one drink of beer in the past 30 days decreased from 12.9% in 2013 to 9.2% in 2016. The percentage of students who reported having at least one drink of a wine cooler in the past 30 days decreased from 7.4% in 2013 to 5.3% in 2016. The percentage of students who reported having at least one drink of other alcohol (liquor, wine, mixed drink, etc.) in the past 30 days decreased from 13.8% in 2013 to 9.9% in 2016. The percentage of students who engaged in binge drinking within the past 30 days decreased from 12.1% in 2013 to 7.4% in 2016. The percentage of students who reported drinking alcohol before the age of 13 was 7.3% in 2016; the national average was 17.2%. (YRBS, 2015).

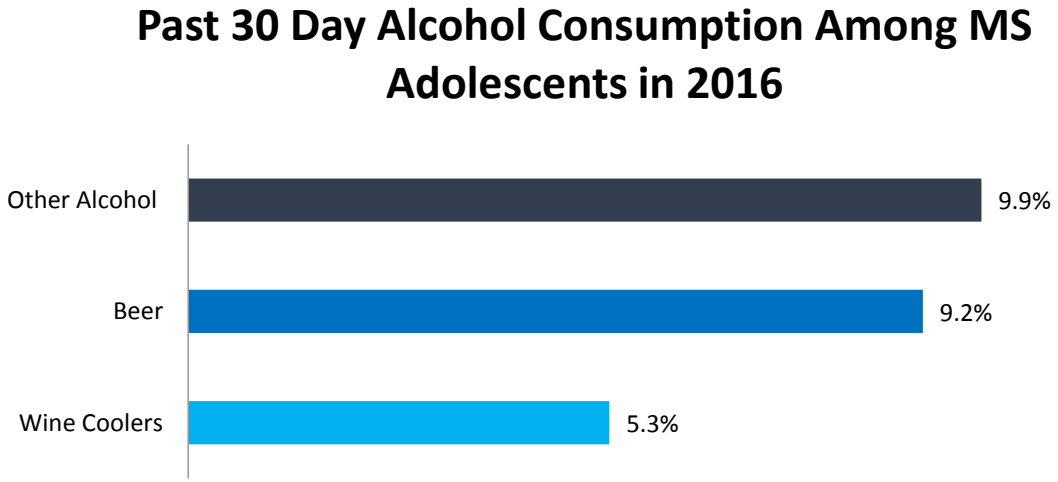

Figure 1: An illustration of past 30 day alcohol consumption among students that participated in the 2016 SmartTrack Survey, grouped by types of alcoholic beverages consumed.

Tobacco Use

The percentage of students who reported cigarette use in the past 30 days was 15.2% in 2015; the national average was 10.8%. (YRBS, 2015) Estimates from the 2016 SmartTrack Survey showed that about 5.9% of 6th - 11th grade students used cigarettes in the past month. The percentage of students who have used chewing tobacco or snuff during the past 30 days decreased from 6% in 2013 to 3.8% in 2016 (SmartTrack, 2013 and 2016). Students reported using e-cigarettes more than any

other tobacco product, at 6.6%. The percentage who smoked a whole cigarette before age 13 was 7.3% in 2016; the national average was 6.6%. (YRBS, 2015).

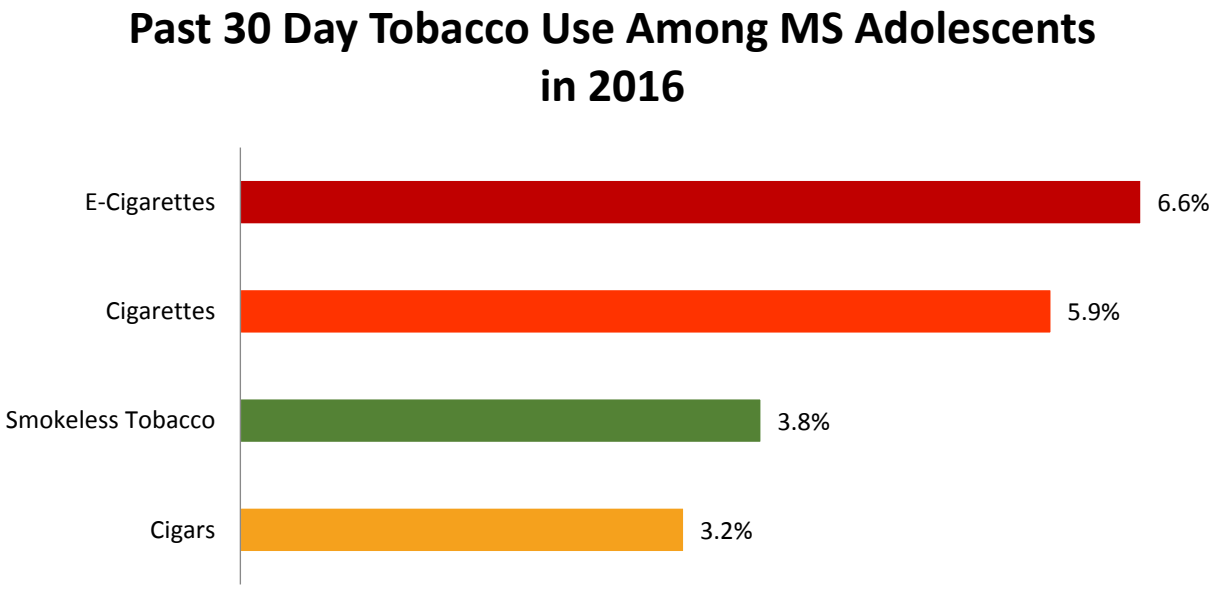

Figure 2: An illustration of past 30 day tobacco use among students that participated in the 2016 SmartTrack Survey, grouped
by different tobacco products consumed.

Other Drug Use

The percentage of students who used any form of cocaine including powder, crack, or freebase one or more times in the past 30 days was 1.7% in 2016. The percentage of students who use heroin one or more times in the past 30 days was 1.4% in 2016. The percentage of students who sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times in the past 30 days was 2.2% in 2016. In 2016, estimated 3.4% of 6^{th} - 11^{th} grade students reported non-medical use of prescription drugs at least once in the past month. The percentage of students who used marijuana one or more times during the past 30 days increased from 6.7% in 2013 to 6.9% in 2016. The percentage of students who tried marijuana for the first time before age 13 years was 4.4% in 2016 down from 8.6% in 2011; the national average was 7.5%. (YRBS, 2015) The percentage of students that have used prescription drugs one or more times without a doctor's prescription (such as Oxycontin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, during their life) in the past 12 months was 6.2%; the national average reported for ever using prescription drugs was 16.8%. (YRBS, 2015).

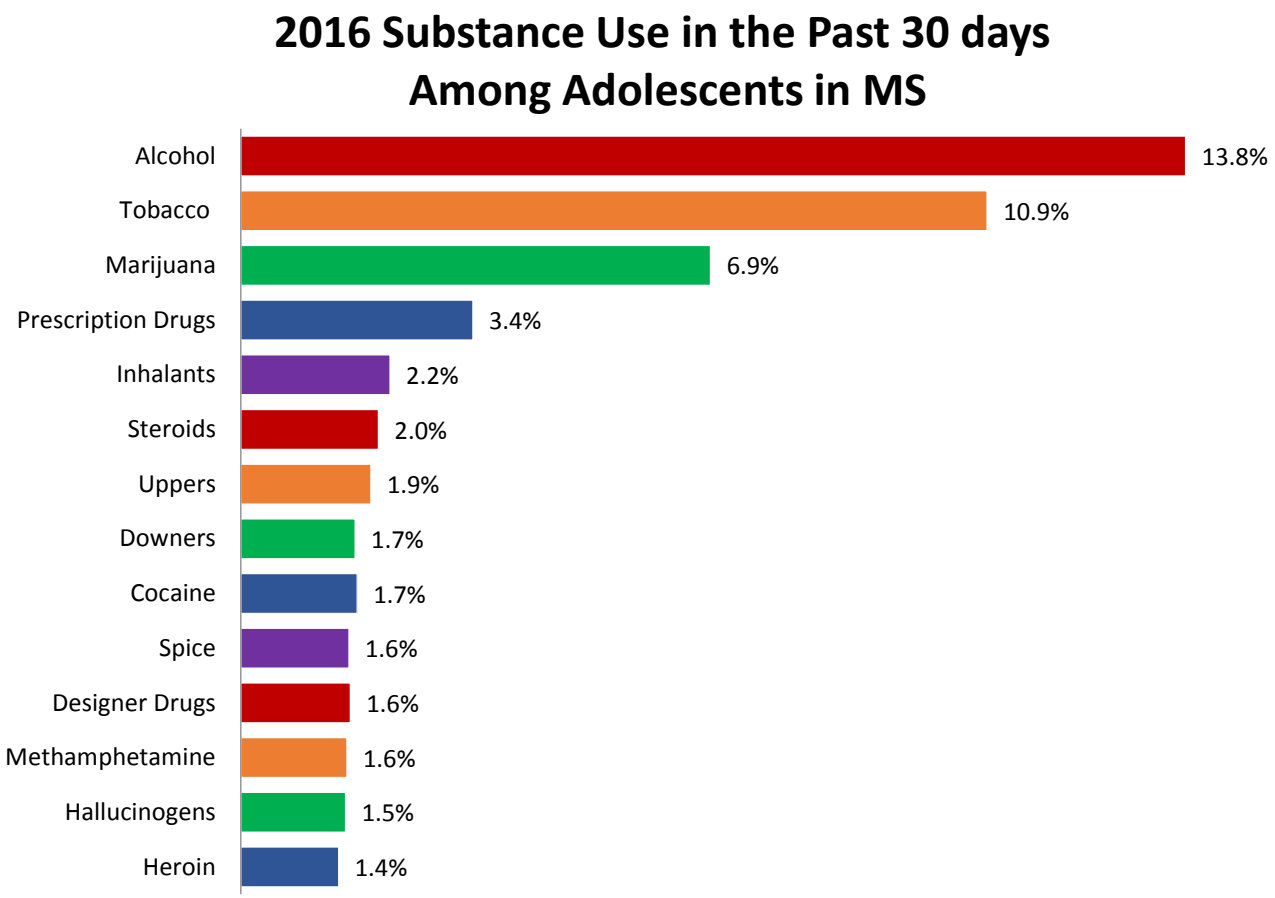

Figure 3: A display of drug use reported in the past 30 days by Mississippi students that participated in the 2016 SmartTrack Survey.

National Survey on Drug Use and Health (NSDUH) for Mississippi

According to statistics cited in SAMHSA's *2014-2015 National Survey on Drug Use and Health (NSDUH)*, the percentage of Mississippians aged 12 or older reporting the use of cocaine or heroin illicit drugs the past year was 1.0% and 0.2%, respectively. For cocaine, this equates to an estimated 0.4% of 12-17 year olds; 1.8% of 18-25 year olds; and 0.9% of persons age 26 or older using cocaine in the past year. For heroin this equates to an estimated 0.1% of 12-17 year olds; 0.3% of 18-25 year olds; and 0.1% of persons age 26 or older using heroin in the past year. Past month marijuana use among Mississippians 12 years and older was 8.6%; grouped by age, there was approximately 9.5% of 12-17 year olds; 21.7% of 18-25 year olds; and 6.2% among persons 26 years or older that reported smoking marijuana in the past 30 days. It is important to note that overall reported use for marijuana has increased since the previous reporting period. Past month tobacco use among Mississippians 12 and older was 25.3%; person age 18 – 25 smoked more often the past month than any other age group, at 31.2%. Approximately 39.5% of Mississippians age 12 or older were past month alcohol users. This further breakdown to an estimated 8.8% of 12-17 year olds; 46.9% of 18-25 year olds; and 42.2% of persons 26 or older were past month alcohol users. An estimated 5.2% of Mississippians age 12 or older reported having an alcohol use disorder in the past year. Rates for alcohol use disorder dependence were higher within the 18-25 year age group (8.9%), with 12-17 year olds and persons older than 26 reporting alcohol use disorder rates of 2.2% and 4.9%, respectively.

Kids Count

Mississippi had an estimated population of 2,988,726 in 2016. The state is predominantly rural, with an estimated 22% of its population reported to be living in poverty, which is the highest rate in the

nation (US Census Bureau, 2016); this translates to about one in five Mississippians living below the poverty line. Approximately 31.5% of Mississippi children under the age of 18 live below the federal poverty level, while 26% of all families and 46% of families with a female householder and no husband present also have incomes below the poverty level. Economically, the lack of a viable non-agriculture-based economy has resulted in stagnant incomes and low-skilled jobs. The link between poverty, mental health, and substance use disorders is undisputable. Furthermore, the challenges associated with living in a rural state often present barrier to the prevention and treatment of substance use disorders and mental health disorders. According to The Annie E. Casey Foundation's *2017 KIDS COUNT Data Book,* the following conditions exist for children in MS today.

CHILD WELL-BEING INDICATORS	STATISTICS		Change From Previous Year	RANK
	National Average	MS		
Percent of children in poverty (2015)	21%	31%	increased	50th
Teen birth rate (Births per 1,000 females ages 15-19) (2015)	22	35	decreased	46th
Infant mortality rate (Death per 1,000 live births) (2015)	5.9	9.3	increased	50th
Percent of children in single-parent families (2015)	35%	48%	increased	50th
Percent of teens not attending school and not working (2015)	7%	10%	unchanged	47th
Percent of teens who are high school dropouts (Ages 16-19) (2015)	4%	5%	unchanged	30th
Child death rate (Deaths per 100,000 Children Ages 1-14) (2015)	16	28	increased	45th
Teen death rate (Deaths per 100,000 teens ages 15-19) (2015)	48	72	decreased	45th

Table 2: The comparison of 2015 child health outcomes in MS compared to national estimates and directional changes that occurred in the previous year is displayed (Kids Count, 2017).

Mississippi HIV/AIDS Data

The MS State Department of Health, Bureau of STD/HIV reported that in 2015 there were 509 newly diagnosed cases of HIV disease. The majority (409 or 80.4%) of the cases were African American while 75 (14.7%) were Caucasian. Persons living with HIV/AIDS in Mississippi in 2014 totaled 8,983. In 2014, there were 6,539 (72.1%) individuals of African American descent living in MS with HIV (MSDH, 2015). This is particularly important to note since African Americans represent only 37.5% of MS's general population (Census, 2016). In 2014, there were 4,746 (25%) individuals of Caucasians descent living in MS with HIV. Out of the 82 counties in MS, the top seven counties in 2015 which had new persons living with HIV were: Hinds (2,238), Harrison (610), Rankin (436), Forrest (358), DeSoto (287), Jackson (246), and Lauderdale (240) (AIDSVu.org, 2014).

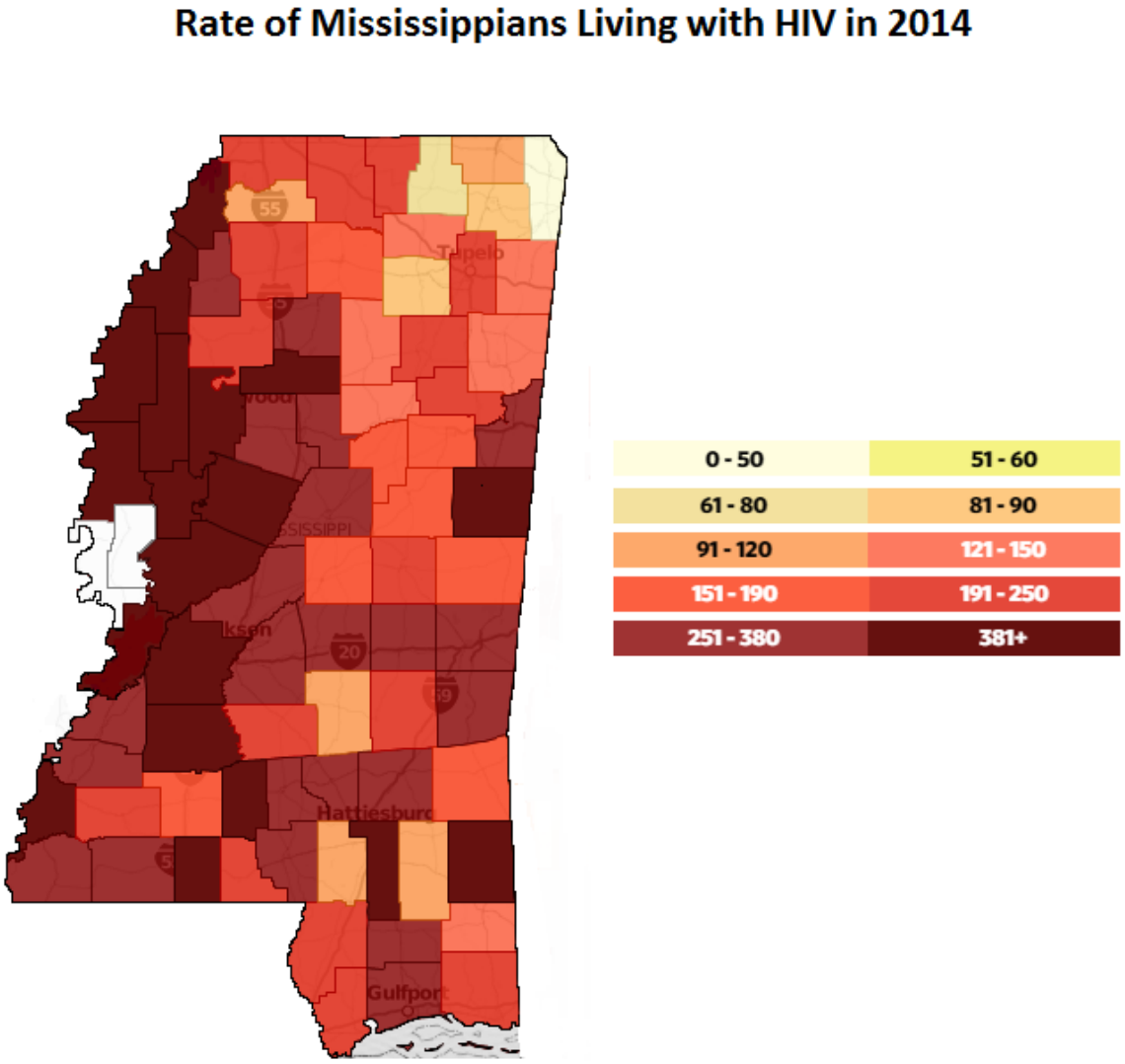

Figure 4: A display of Mississippians living with HIV, by county, in 2014. Counties are color coded by rate of existing cases of HIV per 100,000 (AIDSVu.org, 2014).

Statewide Plan for Substance Use Disorder Prevention, Treatment and Recovery Support

The DMH, Bureau of Alcohol and Drug Services, administers the public system of substance use disorder assessment, referral, prevention, treatment, and recovery support services for the individuals it is charged to serve. It is also responsible for establishing, maintaining, and evaluating the network of service providers which include state-operated behavioral health programs, regional community mental health centers, and other nonprofit community-based programs.

The Bureau of Alcohol and Drug Services strives to achieve and/or maintain high standards through the service delivery systems across the state. Therefore, the bureau is mandated to establish standards for the state's alcohol/drug prevention, treatment, and recovery support programs; assure compliance with these standards; effectively administer the use of available resources; advocate for and manage financial resources; develop the state's human resources by providing training opportunities; and

develop an alcohol/drug data collection system. In order to address the issues of substance use disorders, the bureau believes a successful program is based on the following philosophical tenets:

- Substance use disorders are illnesses which are treatable and preventable.
- Effective prevention services reduce, delay, and prevent substance abuse. It decreases the need for treatment and provides for a better quality of life.
- Substance use disorders are prevalent in all culturally diverse subgroups and socioeconomic categories.
- Services should be delivered in a community setting, if appropriate.
- Continuity of care is essential to an effective substance use disorders treatment program.
- Vocational rehabilitation is an integral part of the recovery process.
- Effective treatment and recovery include delivery of services to the individual and his/her family.
- Individuals in recovery from a substance use disorder can return to a productive role within their community.

The network of services comprising the public substance use disorder treatment system is provided through the following avenues:

Regional Community Mental Health Centers

The community mental health centers (CMHCs) with whom DMH contracts are the foundation and primary service providers of the public substance use disorders services delivery system. Each CMHC serves a designated number of Mississippi counties. There are sixty-seven community-based satellite centers throughout the state which allow greater access to services by the area's residents. The goal is for each Community Mental Health Center to have a full range of treatment options available for citizens in its region.

Substance use disorders services usually include: (1) alcohol, tobacco, and other drug prevention services; (2) general outpatient treatment including individual, group, and family counseling; (3) recovery support (continuing care) planning and implementation services; (4) primary residential treatment services (including withdrawal management); (5) transitional residential treatment services; (6) vocational counseling and employment seeking assistance; (7) emergency services (including a 24-hour hotline); (8) educational programs targeting recovery from substance use disorders which include understanding the disease, the recovery process, relapse prevention, and anger management; (9) recreational and social activities presenting alternatives to continued substance use and emphasizing the positive aspects of recovery; (10) 10-15 week intensive outpatient treatment programs for individuals who are in need of treatment but are still able to maintain job or school responsibilities; (11) community-based residential substance use disorders treatment for adolescents; (12) specialized women's services; (13) priority treatment for pregnant/parenting women; 14) services for individuals with a co-occurring dis- order of substance use disorder and serious mental illness; and, (15) employee assistance programs.

Other Nonprofit Service Agencies/Organizations

Other Nonprofit Service Agencies/Organizations, which make up a smaller part of the service system, also receive funding through the Department of Mental Health to provide community-based services. Many of these free-standing nonprofit organizations receive additional funding from other sources such as grants from other state agencies, community service agencies, donations, etc.

PROCESS FOR FUNDING COMMUNITY-BASED SERVICES

Within the Department of Mental Health, the Bureau of Alcohol and Drug Services is responsible for ad- ministering the fiscal resources for substance use disorder services. The authority for funding programs to provide services to persons in Mississippi with substance use disorder issues was established through state statute.

Funding is provided to community service providers by the Department of Mental Health through purchase Proposals and Application of Services (POS) or grant mechanisms. Funds are allocated by the Department through a Request for Review Process. Requests for Proposals (RFPs) and/or Funding Continuation Applications (FCAs) are disseminated among service providers through the Department's Grants Management office and detail all requirements necessary for a provider to be considered for funding. The RFP/FCA may also address any special requirements mandated by the funding source, as well as Department of Mental Health requirements for programs providing substance use disorders services.

Agencies or organizations submit proposals which address needs of prevention and treatment services in their local communities to DMH for their review. Applications for funding of prevention or treatment programs are reviewed by DMH Bureau of Alcohol and Drug Services staff, with decisions for approval based on (1) the applicant's success in meeting all requirements set forth in the RFP/FCA, (2) the applicant's provision of services' compatibility with established priorities, and (3) availability of resources.

SOURCES OF FUNDING

Sources of funding for substance use disorders prevention and treatment services are provided by both state and federal resources.

Federal Sources

Substance Abuse Mental Health Services Administration

The Substance Abuse Block Grant (SABG), is applied for annually by the Bureau of Alcohol and Drug Services. Detailed goals and objectives for addressing specific federal requirements included in the SABG program are included in this State Plan. The Substance Abuse Block Grant is the primary funding source for DMH to administer substance use disorders prevention and treatment services in Mississippi. The Bureau allocates these awarded funds to its programs statewide. Funds are used to provide the following services: (1) general outpatient treatment; (2) intensive outpatient treatment; (3) primary residential treatment; (4) transitional residential treatment; (5) recovery support services; (6) prevention services; (7)community-based residential substance use disorders treatment for adolescents; (8) special women's services which include day treatment and residential treatment with priority on recovery support activities and programs for pregnant women and women with dependent children; (9) DUI assessment, opioid treatment services, and withdrawal management services for

individuals with a co- occurring disorder. In administering SABG funds, the DMH Bureau of Alcohol and Drug Services maintains minimum required expenditure levels (set aside) for substance use disorders services in accordance with federal regulations and guidelines.

State Sources

Alcohol Tax

In 1977, the Mississippi Legislature levied a three percent tax on alcoholic beverages, excluding beer, for the purpose of using these tax collections to match federal funding, as deemed necessary, in order to fund alcohol treatment and rehabilitation programs. The earmarked alcohol tax is tied directly to the volume of alcoholic beverages sold in the state. Funds from the three percent alcohol tax are used to provide treatment for alcohol use disorders at DMH operated behavioral health programs and community based programs.

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.

REHABILITATION/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 re- habilitation services; employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process and is de- signed 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 dis- orders screening and a primary treatment unit are provided for the inmates at the Mississippi Correctional Facility in Parchman.

<u>Access to Community-Based Transitional Residential Services</u>

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 de-signed for this population. There are also programs that provide services for female ex-offenders and adult males who have been diagnosed with a 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 pro- grams 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 adults due to the aging process of their mind and body. Many older adults also suffer from dementia as well and may require intensive treatment. 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 particular situation, the person's needs may change over time and require different 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 offenders 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).

Mississippi Drug Courts

Mississippi currently has 40 drug courts covering all 82 counties. There are 22 adult felony programs, 3 adult misdemeanor programs, 13 juvenile programs, and 2 family programs. The mission of the drug court is to establish a system with judicial requirements which will effectively reduce crime by positively impacting the lives of substance users and their families. The target population of the program is for anyone whose criminal behaviors are rooted in their substance use. An evaluation process determines whether or not an offender is eligible for the program. As of December 31, 2014, there were 3,483 individuals enrolled in drug courts statewide. There were 725 graduates of the program in 2014. In that same year, statewide participants paid $1,153,101.31 in fines to the county's general fund and $1,337,242.97 in fees that were deposited within the county's local drug court fund to support the program's budget.

House Bill 585, which became effective July 1, 2014, implemented a standardized certification process for all drug courts that requires the programs to implement evidence-based treatment services. House Bill 585 authorizes the State Drug Court Advisory Committee to establish rules relating to the creation of Veteran's Treatment Courts.

Currently, the Bureau of Alcohol and Drug Services allocates funding to support a private, non-profit, free standing community-based program, IQOL (Improving Quality of Life) to implement the ICMS's (Intensive Case Management Services) phase of the Drug Court Program. The case managers work closely with the court system to assist the client in meeting the judicial requirements administered by the court. Clients are offered the incentive of a chance to remain out of jail and the sanction of a jail sentence if they fail to remain drug-free and noncompliant. The BADS, Director of Prevention Services, serves on the State Drug Court Advisory Committee.

Vocational Rehabilitation Services

Each primary residential treatment program provides vocational counseling to individuals while they are in the treatment program. In transitional treatment, the primary focus is assisting the client in securing employment and/or maintaining employment. The Department of Rehabilitation Services, Office of Vocational Rehabilitation, partners with the Bureau of Alcohol and Drug Services in providing some monetary support for eligible individuals in the transitional residential treatment programs.

Tuberculosis and HIV/AIDS Assessment/Educational Services

All individuals receiving substance 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 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 2017-2019 publication was distributed in August of 2017 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.

Priority Areas and Annual Performance Indicators

Statutory Criterion for Substance Abuse Prevention and Treatment Block Grant

1. Responding to the Opioid Crisis
2. Pregnant Women and Women with Dependent Children
3. IV Drug Users
4. HIV/AIDS, STDs, Hepatitis, and Tuberculosis
5. Recovery Support
6. Trauma
7. Co-Occurring Disorders
8. Prescription Drugs
9. Adolescents and Prescription Drug Use
10. Adolescents and Alcohol Use

Criterion #1: Responding to the Opioid Crisis

Goal:

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

Objectives:

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

Strategies to attain the objectives:

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

Indicator #1:	Implement or expand clinically appropriate evidence-based treatment service options and availability.
Baseline Measurement:	There are currently 4 certified OTP's in the state.
1st year target/outcome measurement:	Two (2) additional providers will be certified in the state.
2nd year target/outcome measurement:	An additional two (2) providers will become certified in the state. Certification Database
Data Source:	Certification Database
Description of Data:	The Certification Database contains all certified providers and their certifications

Indicator #2:	Identify and treat opioid abuse during pregnancy.
Baseline Measurement:	Partner with the Division of Medicaid to examine the feasibility of implementing and sustaining a voucher system supporting MAT and psychosocial treatment access for pregnant females.
1st year target/outcome measurement:	Conduct at least two (2) planning meetings between Medicaid and DMH-BADS on developing a voucher system for pregnant women in treatment.
2nd year target/outcome measurement:	Implement a voucher system for pregnant women supporting MAT and psychosocial treatment access for pregnant females.
Data Source:	
Description of Data:	Agendas stating the scope of planning and work to be accomplished.

CRITERION 2: Pregnant Women and Women with Dependent Children

Goal:

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

Objectives:

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

Strategies to attain the objectives:

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 anther 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.

Indicator #1:	The percentage of women served who successfully completed treatment.
Baseline Measurement:	Implementation will begin by January 1, 2018.
1st year target/outcome measurement:	Increase by 2.5% the number of pregnant women who successfully complete treatment during 2018-2019.
2nd year target/outcome measurement:	Increase by 2.5% the number of pregnant women who successfully complete treatment during 2019-2020.
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.

Indicator #2:	The percentage of pregnant women served who utilize Medication Assisted Treatment (MAT) during treatment and successfully complete treatment.

Baseline Measurement:	Implementation will begin by January 1, 2018.
1st year target/outcome measurement:	Increase by 25% the number of pregnant women that have access to MAT during FY 2018-2019.
2nd year target/outcome measurement:	Increase by 25% the number of pregnant women that have access to MAT during FY 2019-2020.
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 the outcome measures:	Many 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 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.

CRITERION 3: Interventions Drug (IV) Users

Goal:

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

Objectives:

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

Strategies to attain the objectives:

All DMH certified substance abuse programs must document and follow written policies and procedures that ensure:

- Individuals who use IV drugs are provided priority admission over non-IV drug users. Individuals who use IV drugs are placed in the treatment program identified as the best modality by the assessment within forty-eight (48) hours.
- 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.
- 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.
- 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.

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

- 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:
    - 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;
    - Referrals for HIV, Hepatitis, and TB services made when necessary.

Indicator #1:	The percentage of IV drug users successfully completed treatment.
Baseline Measurement:	Implementation will begin by January 1, 2018.
1st year target/outcome measurement:	Increase by 1% the number of IV Drug Users who successfully complete treatment after admission.
2nd year target/outcome measurement:	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.

CRITERION 4: HIV/AIDS, STDs, Hepatitis, and Tuberculosis

Goal:

Many 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.

Objectives:

Many 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.

Strategies to attain the objectives:

All individuals receiving treatment for a substance use disorder at any program certified by the DMH will receive a risk assessment for HIV, tuberculosis, hepatitis, and STDs at the time of intake and receive referrals for testing and treatment services if determined to be at high-risk. For individuals in a primary residential setting determined to be at high-risk for tuberculosis, transportation is provided to the location where the assessment will be conducted.

If an individual is determined to be at high-risk for HIV, testing options to that individual are determined by their level of care. Individuals in a primary residential setting will be offered HIV Rapid Testing Services onsite or must be transported to a testing site in the community only until Rapid Testing Program can be implemented. Individuals at high-risk for HIV in outpatient services will be offered HIV Rapid Testing Services or informed of available HIV testing resources available within the community. Individuals at high-risk for HIV in Transitional Residential and Recovery Support Services will be offered HIV Rapid Testing unless the program can provide documentation that the individual received the risk assessment and was offered testing during primary substance abuse treatment. If HIV Rapid Testing is not immediately available, then testing will be offered to the individual or the individual will be informed of available HIV testing resources available within the community. It is planned to routinely make available tuberculosis assessment, treatment (if applicable) and educational services to each individual receiving treatment for substance abuse.

Additionally, individuals will continue to receive educational information and materials concerning HIV, tuberculosis, hepatitis, and STDs, either in an individual or group session during the course of treatment. Individuals' records will continue to be monitored routinely for documentation of these activities by Bureau of Alcohol and Services staff through routine monitoring visits.

Indicator #1:	Many 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.
Baseline Measurement:	Implementation will begin by January 1, 2018.
1st year target/outcome measurement:	50% of the primary residential programs will offer on-site rapid testing for HIV and Hepatitis during 2018-2019
2nd year target/outcome measurement:	60% of the primary residential programs will offer on-site rapid testing for HIV and Hepatitis during 2019-2020
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 the outcome measures:	Training time needed for HIV and Hepatitis rapid testing and the cost could pose an issue for this goal.

CRITERION 5: Recovery Support

Goal:

Increase workforce awareness and understanding of the DMH Operational Standards on Recovery Support Services
Continue to assure that all programs have established a plan and are offering a number of family education groups, workshops and trainings on recovery/recovery supports to the community.

Objectives:

Promote recovery, resiliency, and community integration throughout the state.

Strategies to attain the objectives:

In an effort to continue to increase staff's understanding of the DMH Operational Standards on Recovery Support Services, BADS will continue to provide technical assistance, programmatic development training, and state-wide provider training to all service providers on what Recovery Support Services is and what it should look like for their community.

Indicator #1:	Increase the number of recovery support specialists by 3%.
Baseline Measurement:	Currently there are 60 certified recovery support specialists in the state for SUD.
1st year target/outcome measurement:	Increase the number of recovery support specialists by 3%.
2nd 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.

CRITERION 6: Trauma

Goal:

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

Objectives:

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

Strategies to attain the objectives:

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.

Indicator #1:	Infuse trauma assessments within the clinical assessment phase of intake.
Baseline Measurement:	Implementation will begin by January 1, 2018.

1st year target/outcome measurement:	At least 25 individuals utilize the functional assessment.
2nd 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.

CRITERION 7: Co-Occurring

Goal:

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

Objectives:

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 objectives:

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).

Indicator #1:	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.
1st year target/outcome measurement:	Increase the number of CMHCs to be assessed (DDCMHT) to 50% by the end of grant year 2018.
2nd 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 the	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.

outcome measures:	

CRITERION #8: Prescription Drugs

Goal:

To reduce the number of prescriptions and dosage units.

Objectives:

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

Strategies to attain the objectives:

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

Indicator #1:	Partner with professional associations and medical teaching institutions to educate dentists, osteopaths, nurses, physician assistants, and podiatrists on current opioid prescribing guidelines.
Baseline Measurement:	From January, 2017 to June, 2017, there were 1,722,696 dosage units distributed in Mississippi.
1st year target/outcome measurement:	Reduce the number of dosage units by 10%
2nd year target/outcome measurement:	Reduce the number of dosage units by 10%
Data Source:	Mississippi Prescription Monitoring Program
Description of Data:	All pharmacies input opioid data into the PMP. Data will be collected and analyzed regarding the prescribing changes.

Indicator #2:	Past 30 day use
Baseline Measurement:	3.82% of 6-11th graders report using prescription drugs that were not prescribed to them by a doctor in the past 30 days (2012-2013)
1st year target/outcome measurement:	Reduce rate by 1% in year one
2nd year target/outcome measurement:	Reduce rate by 1% in year two
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 the outcome measures:	We are currently investigating new forms of data collection. We will request technical assistance in this area.

Indicator #3:	In 2015, 4% of Mississippi youth in grades 6-12 reported having used prescription drugs in a way other than how they were prescribed.
Baseline Measurement:	3.82% of 6-11th graders report using prescription drugs that were not prescribed to them by a doctor in the past 30 days (2012-2013)
1st year target/outcome measurement:	Decrease the percentage of youth in grades 6-12 that reported having used prescription drugs in a way other than how they were prescribed. by .5%
2nd year target/outcome measurement:	Decrease the percentage of youth in grades 6-12 that reported having used prescription drugs in a way other than how they were prescribed by .5%
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.

CRITERION #8: Prescription Drugs

Goal:

Reduce prescription drug abuse to protect the health, safety, and quality of life for Mississippi adolescents and young adults.

Objectives:

Reduce past year and past 30-day non-medical use of prescription drugs.

Strategies to attain the objectives:

BADS prevention providers will continue to increase efforts to inform their communities on the dangers of prescription drug abuse.

BADS will continue to work with both state and community level drug taskforce coalitions in implementing programs aimed at educating individuals on prescription drug take back initiatives.

BADS prevention providers will continue to focus available resources on media campaigns and PSAs to assist in educating the general public.

Programs will have implemented evidence based programs, policies, and practices within their communities.

Indicator #1:	Statewide media campaign targeting adolescents on opioid use and misuse.

Baseline Measurement:	5.64% of adolescents 12-17 years of age reported using pain relievers nonmedically in MS, 2013-2014 NSDUHs; or 4% of adolescents in 6th-11th grades reported the illicit use of prescription drugs in the past 30 days, 2013 Mississippi Student Survey
1st year target/outcome measurement:	By December 31, 2019, reduce the percentage of youth ages 12-17 years, reporting the use of non-medical prescription type drugs.
2nd year target/outcome measurement:	By December 31, 2020, reduce the percentage of youth ages 12-17 years, reporting the use of non-medical prescription type drugs.
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.

CRITERION #9: Adolescents

Goal:

Reduce prescription drug abuse to protect the health, safety, and quality of life for Mississippi adolescents and young adults

Objectives:

Reduce past year and past 30-day non-medical use of prescription drugs.

Strategies to attain the objectives:

BADS prevention providers will continue to increase efforts to inform their communities on the dangers of prescription drug abuse.

Indicator #1:	Statewide media campaign targeting adolescents on opioid use and misuse.
Baseline Measurement:	5.64% of adolescents 12-17 years of age reported using pain relievers nonmedically in MS, 2013-2014 NSDUHs; or 4% of adolescents in 6th-11th grades reported the illicit use of prescription drugs in the past 30 days, 2013 Mississippi Student Survey
1st year target/outcome measurement:	By December 31, 2019, reduce the percentage of youth ages 12-17 years, reporting the use of non-medical prescription type drugs.
2nd year target/outcome measurement:	By December 31, 2020, reduce the percentage of youth ages 12-17 years, reporting the use of non-medical prescription type drugs.
Data Source:	National Survey of Drug Use and Health (primary) Mississippi Student Survey (secondary: if NSDUH is unavailable due to changes in the methodology for this question in 2015)
Description of Data:	The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco,

	and illegal drug use and abuse and mental disorders in the U.S. civilian, non-institutionalized population, age 12 and older. The Mississippi Student Survey is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and other illicit drug use among 6th-11th grade Mississippi students that can examine what is happening on the community level by county and school district.
Data Issues/caveats that affect the outcome measures:	2015 NSDUH Redesign Changes and Impact: The NSDUH questionnaire underwent a partial redesign in 2015. The prescription drug questions for pain relievers, tranquilizers, stimulants, and sedatives were redesigned to shift the focus from lifetime misuse to past year misuse. Additionally, questions were added about any past year prescription drug use, rather than just misuse. A separate section with methamphetamine questions was added, replacing the methamphetamine questions that were previously asked within the context of prescription stimulants. Substantial changes were also made to questions about smokeless tobacco, binge alcohol use, inhalants, and hallucinogens. These changes led to potential breaks in the comparability of 2015 estimates with estimates from prior years. Consequently, these changes potentially affected overall summary measures, such as any illicit drug use, and other measures, such as initiation, SUDs, and substance use treatment. Additionally, certain demographic items were changed as part of the partial redesign. Employment questions were moved from the computer-assisted personal interviewing (CAPI) section to the audio computer-assisted self-interviewing (ACASI) section of the questionnaire. Education questions were updated, and new questions were added on disability, English-language proficiency, sexual orientation of adults, and military families. Due to the potential breaks in comparability, many estimates from prior years have been noted in the detailed tables as not comparable due to methodological changes. These include measures of overall illicit drug use, use of illicit drugs other than marijuana, use of hallucinogens, inhalants, and methamphetamine, misuse of psychotherapeutics, binge and heavy alcohol use overall and among females, smokeless tobacco, and substance use treatment. Additionally, estimates by education and current employment have been noted as not comparable. Other topics, such as the mental health topics, did not undergo major changes and therefore are considered comparable. There are new tables for 2015 pertaining to any past year prescription drug use. Within these tables, corresponding estimates from prior years are noted as unavailable. The newly defined any use of prescription drugs includes both use as directed by a doctor as well as misuse. Misuse includes use in any way not directed by a doctor, including use without a prescription of one's own, use in greater amounts, more often or longer than told to take a drug, or use in any way not directed by a doctor. The detailed tables no longer use the term "nonmedical use" and instead use the term "misuse." For more specific information about each of the 2015 NSDUH changes, see Section C of the 2015 National Survey on Drug Use and Health: Methodological Summary and Definitions.

	Because of the change in focus of the 2015 NSDUH questions for specific psychotherapeutic drugs from the lifetime to the past year period among respondents who last misused any prescription psychotherapeutic drug in any of the four categories (pain relievers, tranquilizers, stimulants, or sedatives) more than 12 months ago, there appeared to be an underreporting of lifetime prescription drug misuse compared with prior years. This might be because respondents are no longer presented with examples of drugs that formerly were available by prescription in the United States but are no longer available and because there are fewer questions asking about lifetime use. These respondents who did not report misuse that occurred more than 12 months ago would be misclassified as still being "at risk" for initiation of misuse of prescription drugs in that psychotherapeutic category (i.e., individuals who initiated misuse more than 12 months ago are no longer at risk for initiation). For this reason, the tables do not show percentages for initiation of misuse of psychotherapeutic drugs among individuals who were at risk for initiation. The tables also do not show estimates for lifetime psychotherapeutic drug use. For more specific information about each of the 2015 changes, see Sections B.4.1 and B.4.2 in Section B of the 2015 National Survey on Drug Use and Health: Methodological Summary and Definitions. To evaluate the changes from the redesign, a 12-month redesign impact assessment was completed. Analyses were conducted on a subset of variables associated with the detailed tables to check for potential trend breaks, including the risk and availability measures. After significant differences between 2015 and previous years were found for 16 of 17 raw risk and availability variables during an initial analysis, logistic regression models were run on dichotomous recodes. All of the perceived risk of harm associated with substance use measures, yielded a significant increase in 2015 compared with previous years. Extreme weights and missing rates were investigated to ensure these were not the cause of the difference. As more data become available, trends over time will be further analyzed to determine comparability. Currently, estimates for these measures in the detailed tables for years prior to 2015 have been noted as not reported due to measurement issues.

CRITERION #10: Adolescents Alcohol Use

Goal:

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

Objectives:

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

Strategies to attain the objectives:

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.

Indicator #1:	Adolescent past 30-day use
Baseline Measurement:	13.8% (29,000) of youth ages 12-17 reported Alcohol use in the past month
1st year target/outcome measurement:	Reduce by 1% in year one
2nd year target/outcome measurement:	Reduce by 1% in year two
Data Source:	Smarttrack 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).

CRITERION #11: Adolescents Marijuana Use

Goal:

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

Objectives:

Reduce past 30 days use among 12-17 year olds.

Strategies to attain the objectives:

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 public across diverse social groups (gender, race-ethnicity, educational levels, and sub-state regions) on the dangers of marijuana use through evidence based strategies.

Indicator #1:	Past 30-day use
Baseline Measurement:	6.7% (13,000) of youth ages 12-17 reported marijuana use in the past 30 days
1st year target/outcome measurement:	Reduce rate by 1.5% in year one
2nd year target/outcome measurement:	Reduce rate by 1.5% 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 the outcome measures:	None foreseen.

BUREAU OF ALCOHOL AND DRUG SERVICES
PROJECTED EXPENDITURES FOR FY 2018
ACTUAL EXPENDITURES FOR FY 2016-2018

FEDERAL/ STATE	FUNDING SOURCE	PROJECTED FY 2018	ACTUAL FY 2017	ACTUAL FY 2016
Federal	Substance Abuse Block Grant	$13,777,421	$13,803,568	$13,705,865
	MS Prevention Partnership Grant	N/A	N/A	$876,168
	MS State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Grant	N/A	$950,000	$950,000
	MS Prevention Alliance Communities and Colleges Grant	$1,648,188	$1,648,188	$1,648,188
	MS State Targeted Response to the Opioid Crisis Grant	$3,584,702	$3,584,702	N/A
Total Federal		**$19,010,311**	**$19,986,458**	**$17,180,221**
State of MS				
	3% Alcohol Tax	$6,470,268	$6,470,268	$6,491,446
	State General Funds	N/A	N/A	$412,939
Total State		**$6,470,268**	**$6,470,268**	**$6,904,385**
Grand Total		**$25,480,579**	**$26,456,726**	**$24,084,606**

Summary

It is the goal of the Mississippi Department of Mental Health-Bureau of Alcohol and Drug Services to ensure that all Mississippians can lead healthy lives free of any substance use disorders. Supports include primary residential treatment, transitional residential treatment, intensive outpatient services, and recover support services. These services are offered through regional community mental health centers as well as free-standing agencies, funded through a variety of federal and state sources.

Prevention Works……..Treatment is Effective……..People Recover.