Mississippi

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 01/22/2020 4.43.23 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 809399926

Expiration Date

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

Agency Name Mississippi Department of Mental Health

Organizational Unit Bureau of Behavioral Health/Addictive Services

Mailing Address 239 North Lamar St., 1101 Robert E. Lee Bldg., Suite 1001

City Jackson

Zip Code 39201

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

First Name Jake

Last Name Hutchins

Agency Name MS Department of Mental Health

Mailing Address 239 North Lamar St

City Jackson

Zip Code 39201

Telephone 6013591288

Fax 6013596672

Email Address jake.hutchins@dmh.ms.gov

State CMHS DUNS Number

Number 809399926

Expiration Date

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

Agency Name Mississippi Department of Mental Health

Organizational Unit Bureau of Community Services

Mailing Address 239 North Lamar Street, 1101 Robert E. Lee Building

City Jackson

Zip Code 39201

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

First Name Diana

Last Name Mikula

Agency Name Mississippi Department of Mental Health

Mailing Address	239 North Lamar Street, 1101 Robert E. Lee Building
City	Jackson
Zip Code	39201
Telephone	(601) 359-1288
Fax	601-359-6295
Email Address	diana.mikula@dmh.ms.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	9/3/2019 5:18:55 PM
Revision Date	11/26/2019 11:02:51 AM

VI. Contact Person Responsible for Application Submission

First Name	Jake
Last Name	Hutchins
Telephone	(601) 359-1288
Fax	(601) 359-6295
Email Address	jake.hutchins@dmh.ms.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: Mississippi

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

Signature of CEO or Designee[1]: Diana S. Mikula

Title: Executive Director

Date Signed: 9/3/19
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

Diana S. Mikula, Executive Director

1101 Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201

(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

October 18, 2019

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Division of Grants Management

Dear Wendy Pang, GMO:

I certify that the Mississippi State Department of Mental Health and all subrecipients of the Substance Abuse Prevention & Treatment Block Grant number 6 B08 TI010030-19M001 will comply with the following Notice of Award language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See e.g., 45 C.F.R. 75.300(a) (requiring HHS to "ensure that Federal funding is expended... in full accordance with U.S. statutory... requirements.); 21 U.S.C. 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,

Jake Hutchins

Jake Hutchins, SSA, Bureau Director
Single State Authority
Bureau of Behavioral Health Services

cc Spencer Clark, SPO

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
POST OFFICE BOX 139 • JACKSON, MISSISSIPPI 39205 • TELEPHONE: (601) 359-3150 • FAX: (601) 359-3741 •
www.governorbryant .com

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
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    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

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

Signature of CEO or Designee[1]: _____

Title: Executive Director, Mississippi Department of Mental Healt

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

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

Signature of CEO or Designee[1]: Diana S. Mikula

Title: Executive Director Date Signed: 07/30/19

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name

Diana S. Mikula

Title

Executive Director

Organization

Mississippi Department of Mental Health

Signature: Diana S. Mikula Date: 07/30/19

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

PHIL BRYANT
GOVERNOR

September 1, 2015

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

Dear Ms. Simmons:

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

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

Sincerely,

Phil Bryant
GOVERNOR

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201

(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Diana S. Mikula - Executive Director

10/18/2019

I certify that the Mississippi Department of Mental Health and all sub-recipients will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Jake Hutchins

Jake Hutchins, Director
Bureau of Behavioral Health Services
Mississippi Department of Mental Health

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Diana S. Mikula

Title

Executive Director

Organization

Mississippi Department of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Mississippi Department of Mental Health (DMH) does not actively participate or will not conduct any form of lobbying.

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Step 1: Assessment of the Strengths and Needs of the Service 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 Bureau of Administration works in concert with all Bureaus to administer and support development and administration of mental health services in the state. The Bureau oversees the accounting/payroll, auditing, and grants management functions of the agency. Information Systems is also a part of the bureau.

The Bureau of Behavioral Health Services is responsible for planning, development and supervision of an array of services and supports for children/youth and adults in the state with serious emotional disturbance, serious mental illness and substance use disorders. The Bureau is comprised of three areas including State-Operated Programs, Community Mental Health Services, and Addictive Services. The Bureau is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services 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 Certification and Quality Outcomes is responsible for ensuring the safe provision of high quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes three divisions: Certification, Incident Management, and Professional Licensure and Certification (PLACE).

The Bureau of Human Resources is responsible for employment and workforce development. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. The Bureau also oversees the Contract Management of the agency's contract workers and independent contractors assuring compliance with state rules and regulations.

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 State-Operated Programs, ID/DD Waiver program, and the IDD Community Support Program. 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 and Planning 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 all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects.

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.

Administration of Community-Based Mental Health Services

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set 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. The DMH is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in, and/or facilitates numerous avenues for ongoing communication with consumers, family members, and services providers.

State Mental Health Agency's Authority in Relation to Other State Agencies: The DMH is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance use services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan. The role of State agencies in the delivery of behavioral health services is addressed in: Support of State Partners.

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 Rita Berthay, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Region IV Mental Health Services Jason Ramey, Interim Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 6:	Life Help

Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower, Bolivar, Washington, Sharkey, Issaquena	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 Russ Andreacchio, 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	A Clear Path: Southwest Mississippi Behavioral Health 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 Mona Gauthier, 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 Vickie Taylor, Interim Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14:	Singing River Services

George, Jackson	Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Behavioral Health, Inc. Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Strengths and Needs of the Service System

Strengths: Children with Serious Emotional Disturbance (SED) and Their Families

- DMH was awarded a four year System of Care Expansion and Sustainability Agreement beginning September 30, 2017. Two local community mental health center regions are implementing the program in five counties that targets underserved children and youth (ages 3- 21) who are involved in the child welfare system and /or the juvenile justice system, referred to "crossover youth", and those at risk for becoming crossover youth, and their families. Crossover XPand provides evidence based practices; training for professionals, youth and their families; and, resources and informal supports to youth enrolled in the program.

- The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances and complex needs that usually require the intervention of multiple state agencies. On the local level, the DMH provides flexible funding to 56 local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Child Protection Services (CPS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services.

- The DMH and the Division of Children's Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training staff from other child and family support service agencies. Collaborative training initiatives include Wraparound Facilitation and System of Care by the Mississippi Wraparound Institute; Youth Suicide Prevention; Cultural Diversity; Trauma-Informed Care; nonviolent crisis intervention (CPI); and contractual services with nationally certified trainers and learning collaboratives for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. The DMH continues to fund ten CMHCs for the provision of mental health services in the local detention centers. Services include

assessments, Community Support Services, SPARCS (group therapy), Cognitive Behavioral Therapy (CBT), Wraparound Facilitation, and medication monitoring as well as training of juvenile detention center staff.

- The DMH, in collaboration with the Division of Medicaid and the University of Southern Mississippi's School of Social Work, developed the Mississippi Wraparound Institute (MWI). MWI employs and/or supports four nationally certified Wraparound Coaches to train, implement and expand high fidelity Wraparound Facilitation across the state. Currently, twelve mental health providers are certified by DMH to provide Wraparound Facilitation to over 1,700 children/youth annually.

- Through an initiative with NAMI MS, DMH along with several CMHCs and youth developed a specialized curriculum for Youth and Young Adults. This curriculum has been integrated into the existing Certified Peer Support Specialists training with modules specifically designed for youth/young adults such as Cultural Diversity; Youth Driven System of Care; Suicide Prevention; Self-Care; Youth Advocacy and Communication; and, Independent Living Resources.

- NAVIGATE is an evidence-based program designed to assist youth and young adults who have experienced their first psychiatric episode. DMH added three (3) additional NAVIGATE teams for a total of five (5) teams located throughout the State. The NAVIGATE teams use the NIMH recommended model Coordinated Specialty Care Teams for First Episode Psychosis (FEP). The teams continue to receive ongoing training and technical assistance from the NAVIGATE consultants.

Needs: Children with Serious Emotional Disturbance (SED) and Their Families

- Decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers. Availability of additional workforce, particularly psychiatric/medical staff at the local community level, specializing in children's services, is an ongoing challenge in providing and improving services.

- Address children with co-occurring disorders of serious emotional disturbance (SED) and intellectual and developmental disabilities (IDD) in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross-system collaboration and education.

- Continue work to improve the information management system to increase the quality of existing data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes. This work should proceed

with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Expand intensive home- and community-based services, such as the Division of Medicaid's MYPAC program, to additional providers in the state. Mississippi Youth Programs Around the Clock (MYPAC) is an all-inclusive home and community- based program that assists children and youth up to the age of twenty-one (21) with serious emotional disturbance (SED) in gaining access to needed mental health services. The MYPAC program follows the high fidelity Wraparound process and is offered as an alternative to traditional Psychiatric Residential Treatment Facilities (PRTF).

- Continue to expand and explore financing options to sustain System of Care programs with other child-serving systems such as juvenile justice and child protection services. DMH, other system partners, and certified providers will need to address any changes to Medicaid that will have an impact on children's behavioral health services. DMH will continue to collaborate with the two behavioral health managed care organizations to improve access to appropriate services

Strengths: Services for Adults with Serious Mental Illness (SMI)

- Implementation of the comprehensive service system for adults with serious mental illness reflects the DMH's long-term commitment to providing services, as well as supports, that are accessible on a statewide basis.

- Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24–hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and are trained in de-escalation techniques.

- The DMH funds eight (8) 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

- The DMH also operates two, 50–bed acute psychiatric hospitals for adults. The acute care/crisis services are located in the north and in the south part of the state.

- The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. MCeRTs assess adults and children with mental illness, substance use, and intellectual and developmental disabilities. MCeRTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.

- The Bureau of Behavioral Health Services coordinates the Peer Support Specialist Program. This program is designed to promote the provision of quality Peer Support Services and to enhance employment opportunities for individuals with serious mental illness, substance use, and intellectual/developmental disabilities. Certified Peer Support Specialists are required by the DMH to be an integral component of PACT and MCeRT.

- The Bureau of Behavioral Health Services oversees the Peer Review Process for the DMH using The Council on Quality Leadership's Personal Outcome Measures © to assess the impact of services on the quality of life for the people receiving services. Individuals and family members are trained to conduct interviews to determine if outcomes are present for the individual and if the supports needed are present in order to achieve those outcomes. The Bureau of Behavioral Health Services maintains the commitment to ensure individuals and family members have the skills and competencies needed for meaningful participation in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs.

- The Office of Consumer Support is responsible for maintaining a 24–hour, 7–days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide Prevention Lifeline. The Office of Consumer Support responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.

- The DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. The sites are in Regions 2, 7, 10, and 12. New Supported Employment sites are Regions 3, 4, 8, 9, 11, 14, and 15 with a goal of offering supported employment to 175 individuals with serious mental illness.

- Trainers in both the adult and youth versions of Mental Health First Aid have been certified by the DMH. Mental Health First Aid is an education program that helps the public identify, understand, and respond to signs of mental illness, substance use disorders and behavioral disorders. These trainers provide education to community leaders including: pastors, teachers, and civic groups, and families and friends who are interested in learning more about mental health issues.

- All DMH Behavioral Health Programs have implemented person-centered discharge practices which are in-line with the agency's transformation to a person-centered and recovery oriented system of care.

- The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults

about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.

- The DMH continues to provide Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members. ASIST is a 2−day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.

- Mississippi has ten (10) Programs of Assertive Community Treatment Teams (PACT) that serve the following counties: Region 3 (serves Lee County), Region 4 (serves DeSoto, Prentiss, Alcorn, Tippah, and Tishomingo Counties), Region 6 (serves Leflore, Holmes, and Grenada Counties), Region 8 (serves Madison and Rankin Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

- The Specialized Planning Options to Transition Team (SPOTT) is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.

Needs: Services for Adults with Serious Mental Illness (SMI)

- For most people with a mental illness, employment is viewed as an essential part of their recovery. Most people with severe mental illness want to work as it is a typical role for adults in our society and employment is a cost-effective alternative to day treatment. Approximately 2 of every 3 people with mental illness are interested in competitive employment but less than 15% are employed due to lack of opportunities and supports.

- The DMH has chosen to develop and make available supported employment services based on the Dartmouth & Individual Placement and Supports Model (IPS). IPS supported employment helps people with severe mental illness work at regular competitive jobs of their choosing. Although variations of supported employment exist, IPS (Individual Placement and Support) refers to the evidence-based practice of supported employment.

- People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Approximately 40% of clients who obtain a job with help from IPS become steady workers and remain competitively employed a decade later.

- Continued work to increase access and to expand safe and affordable community-based housing options and housing related supports statewide for persons with serious mental illness is needed to support recovery. Accomplishing this goal will involve focusing the system response on supporting individuals to choose among community-based options for a stable home, based on their individual needs and preferences, which is consistent with the best practice of Permanent Supportive Housing (PSH).

- The DMH is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. The DMH makes grant funding available to the Lauderdale County Sheriff's Department to provide training to law enforcement to facilitate the establishment of Crisis Intervention Teams (CIT) in the state. Additionally, DMH provides funding through a SAMHSA grant to Region 12, Pine Belt Mental Heatlhcare Resources, for CIT expansion in the southern half of the state.

- Continued focus on improving transition of individuals from behavioral health centers back to their home communities is needed. The development of strategies to better target and expand intensive supports through a team approach is being addressed. The DMH will continue to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.

- Work to improve the quality of data contained in the information management system, as well as to expand data analysis, continues. The goal is to integrate new and existing data into a comprehensive quality improvement system.

Underserved Racial and Ethnic Minority and LGBT Populations

The Mississippi Department of Mental Health addresses the needs of racial and ethnic minorities and LGBT populations in a variety of ways. The DMH staff has been trained as trainers in the California Brief Multicultural Competence Scale (CBMCS) Training Curriculum. The CBMCS Training is intensive, didactic, and interactive as well as a widely regarded training curriculum that provides tools for working with diverse populations. DMH also partnered with the Mississippi Department of Health, Health Equity Department in training staff as Train the Trainers in the curriculum, Cultural Competence in Health and Human Services. The goal of this one day training is to reduce disparities in access to public and community services through the provision of culturally and linguistically appropriate services**.** DMH also received technical assistance regarding cultural and linguistic competence from The Department of Child &Family Studies (CPS) at the University of South Carolina and the University of South Florida. In addition, the Department of Mental Health collaborated with System of Care communities to create a Behavioral Health Disparities Impact Statement. This statement describes a plan of how grantees will use data to monitor disparities and implement strategies to improve access, service use, and outcomes among the disparate population.

DMH also partners with the Mississippi Safe Schools Coalition which provides Safe Zone training to communities across the state including current System of Care grantee sites. Safe Zones provide LGBTQ youth with an environment that is supportive, understanding, and trustworthy. Staff are trained and prepared to provide youth in need with help, advice, or simply, someone to listen. The Spectrum Center in Hattiesburg, is a resource center and an advocate for the LGBTQ+ community, partners with the SOC site in Hattiesburg and provides training to the staff and community

American Indians

The Mississippi Department of Mental Health and the Mississippi Band of Choctaws collaborate to promote mental health awareness and education. Staff from the Mississippi Band of Choctaws Behavioral Health Services participate and assist in planning the Annual Statewide Trauma Conference sponsored by DMH. Additionally, a staff member from the Mississippi Band of Choctaws Behavioral Health Services participates on the DMH Multicultural Task Force. The mission of this task force is to promote an effective, respectful working relationship among all staff to include public and private agencies, and to provide services that are respectful to and effective with clients and their families from diverse backgrounds and cultures. In turn, staff from DMH participates and assists in planning the Annual Youth Conference sponsored by Choctaw Behavioral Health Services. The local governance council with a System of Care community also includes a representative from the Mississippi Band of Choctaws Behavioral Health Services. An individual interested in or in need of mental health services can find contact information for the Mississippi Band of Choctaws Behavioral Health Services on the current Mississippi Department of Mental Health Website.

Persons with Disabilities

Children and youth with disabilities, such as hearing and/or visual impairments, are served initially by local MAP (Making a Plan) Teams. If local resources are unavailable, the child or youth is referred to the State-Level Interagency Case Review/ MAP Team, which operates under an interagency agreement, and includes representatives from the Department of Mental Health; the Department of Child Protection Services; the Division of Medicaid; the Attorney General's Office; the Department of Health; the Department of Education, the Department of Rehabilitation Services and Families As Allies for Children's Mental Health. The team meets once a month and on an as-needed or emergency basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need specialized or support services. Representatives from the Mississippi School for the Deaf and Blind participate as needed on the team and work in collaboration with staff from the Division of Children and Youth Services to develop appropriate plans to meet the needs of children and youth in our state with hearing and visual challenges.

Military Men and Women

While our military and its members are strong, there are times when they too struggle with stress, anxiety, depression and even thoughts of suicide. Sometimes military men and women feel embarrassed or ashamed to seek help and others may not know what help is available. Members of the military make a promise to protect our country. Mississippians are now making a promise to support them when they are on and off the field of battle. The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families. The campaign, Operation Resiliency, reaches National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. Stress can be a part of everyday life for many people. However, members of the military can face a constant and severe stress that many civilians may never know. It can lead to depression, anxiety, relationship problems, aggression, thoughts of suicide, financial problems, accidents, alcohol and drug use, domestic violence and hopelessness. It is important for members of the military to understand when to seek help.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service System

Adults

An adult with SMI refers to persons ages 18 and older; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Crisis Response

Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24–hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and trained in de-escalation techniques. MCeRT Teams are available in all 14 community mental health center regions. CIT teams are located in Desoto County, Jones County, Lauderdale County, Forrest County, Lamar County, Pike County, and Harrison County.

Crisis Stabilization Units

The DMH funds eight 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state. All CSUs take voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

Housing
The Creating Housing Options in Communities for Everyone (CHOICE) program is funded by the State of Mississippi. It is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and Mississippi's Community Mental Health Centers. The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance, with supportive mental health services through Integrated Supportive Housing.

Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program.

PACT Teams
Mississippi has ten Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto, Alcorn, Tippah, Tishomingo, and Prentiss Counties), Region 6 (serves Leflore County, Holmes County, and Grenada County), Region 8 (serves Madison and Rankin Counties), Region 9 (serves Hinds County), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

Supported Employment
The DMH utilized legislative appropriated community expansion general funds to provide 4 pilot program sites (Regions 2,7,10, and 12) to begin implementation of supported employment services for adults living with mental illness in Mississippi. The DMH collaborates with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental illness. Currently, in addition to the 4 pilot sites initially funded, supported employment is now being provided in Regions 3,4,8,9,11,14,and 15.

Older Adults
Day service programs are community-based programs designed to meet the needs of adults with physical and psychosocial impairments. There are currently two programs operating in the state. The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets. Additionally, Senior Psychosocial Rehabilitation Programs are offered through the CMHCs and include structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs.

Intensive Community Support Service
Intensive Community Support Services are a key part of the continuum of mental health services and supports for people with serious mental illness. Intensive Community Support Services promote independence and quality of life through the coordination of appropriate services and the provision of

constant and on-going support as needed by the consumer. The direct involvement of the consumer and the development of a caring, supportive relationship between the Intensive Community Support Specialist and the consumer are integral components of the Intensive Community Support process. Intensive Community Support Services is responsive to consumers' multiple and changing needs, and plays a pivotal role in coordinating required services from across the mental health system as well as other service systems (i.e., criminal justice, developmental services, and addictions). The priority population for intensive community support services is people who meet the definition for serious mental illness and require on-going and long-term support. Intensive Community Support Services are distinguished from usual Community Support Services by engagement in community settings of people with severe functional impairments traditionally managed in hospitals, an unusually low client to staff ratio, multiple visits per week as needed (high intensity input), and interventions primarily in the community rather than in office settings. Intensive Community Support Services are currently being offered at all 14 of our CMHC's.

Psychosocial Rehabilitation Services (PSR)

Psychosocial Rehabilitation Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. PSR is a core service and is offered at the 14 CMHCs and five (5) private providers.

Recovery Supports

The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented. Recovery Supports include Certified Peer Support Specialists who are employed by DMH certified programs to work with individuals receiving services in achieving their hopes, dreams, and goals, assist the DMH Certification Team in conducting certification visits of DMH certified providers, and provide training in conjunction with DMH staff on Recovery-Oriented System of Care. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Personal Outcome Measures (POM) are a powerful tool for evaluating personal quality of life and the degree to which providers individualize supports to facilitate outcomes. The results from POM interviews give a voice to people receiving services. All CMHCs in the state participate in the POM interview process. The data is compiled and utilized to strengthen Mississippi's efforts to transform to a person centered, recovery-oriented system of care. DMH also supports the operation of the Association of Mississippi Peer Support Specialists (AMPS).

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

Children and Youth

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious emotional disturbance among children and adolescents in Mississippi. According to URS Table 1, the estimated number of children, ages 9–17 years in Mississippi in 2017 is 370,504. Mississippi remains in the group of states with the highest poverty rate (27.7% age 5–17 in poverty, based on URS Table 1). Therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2017 are as follows:

- Within the broad group (9–11%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 11–13% or from 40,755 – 48,166

- Within the more severe group (5–7%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 7–9% or from 25,935– 33,345

Adults

Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi in 2017. URS Table 1 reports that there are 2,257,249 adults in Mississippi (ages 18 years +). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2017, ages 18 years and above, is 121,891 with a lower limit estimate of 83,518 and an upper limit estimate of 160,265.

The following table shows the number of adults (age 18 and above) and children (17 and below) who received mental health services through the public community mental health system during FY 2018 (DMH Annual Surveys, FY 2018). This data excludes the number of individuals who received services in the private sector or in Mississippi's six (6) state operated behavioral health programs.

State Fiscal Year	Under 18	18 and older
FY 2018	37,441	66,359

Criterion 3: Children's Services

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

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 14 community mental health/IDD commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, intensive home/community-based services, family education and prevention/early intervention services. Public inpatient services are provided directly by the DMH (described further later under this criterion). The DMH remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State-Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Mobile Crisis/Emergency Response Teams, Medication Maintenance, Intensive Home/Community Based Services, Wraparound Facilitation, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early and Periodic Screening and Diagnostic Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group, and psychological and developmental evaluations.

Interagency Collaboration for Children and Youth with SED

Interagency collaboration and coordination of activities is a major focus of the Department, the Division of Children and Youth Services and the Planning Council, and exists at the state level and in local and regional areas, encompassing needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives explained below are the State-Level Interagency Case Review/ MAP Team, the Making A Plan (MAP) Teams, the Executive Steering Committee (ESC) for all System of Care programs and participation in a variety of state-level interagency councils and committees.

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Child Protection Services, Department of Health, Department of Education, the Attorney General's Office, Families As Allies for Children's Mental Health, Inc., and representatives from Magnolia Health, UnitedHealthcare Community Plan, and Molina Healthcare. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or

support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Non-profit children's behavioral health providers, local law enforcement, youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. This wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 14 community mental health regions across the state.

The Executive Steering Council acts as the Executive Council for the Mississippi System of Care Grants, Mississippi State Youth Treatment Enhancement and Dissemination Project (SYT-ED) and other grants, as approved by the ESC, to provide technical assistance and guidance to the local project sites; and to provide leadership for the management and operation of the projects. In addition to other tasks, this committee meets monthly and participates on the subcommittees of the Statewide Affinity Group, ensures that effective support and technical assistance are provided to the grantee, votes on budget issues, and advocates on a youth's behalf or on behalf of other youth and families who may not have found their voice. Membership of the council includes DMH Director or designee of the Division of Children and Youth Services, Division of Alcohol and Drug Services, Bureau of Behavioral Health Services, a Chairperson and Co-Chairperson, at least one local-level Project Coordinator, and at least one representative from family advocacy networks, a faith-based organization, a juvenile justice entity, the Attorney General's Office, the MS Department of Child Protection Services, the MS Department of Education, the MS Department of Vocational Rehabilitation, MS Division of Medicaid, a continuous quality improvement/evaluation entity, a post-secondary education entity, a community college, certified peer support specialist, at least one (1) youth and one (1) family/parent representative.

Provision of Evidence-Based Practices

Wraparound Initiatives in Mississippi

The Division of Children and Youth Services continues to partner with the Division of Medicaid's MYPAC Program to fund state-wide training on Wraparound Facilitation for providers of children/youth services including the community mental health centers, ***five*** non-profit organizations, parents and social workers. The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work for the Mississippi Wraparound Institute (MWI). MWI has four nationally certified Wraparound

Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. In addition, the Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT). DMH trainers provide trainings upon request to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies. In June 2017, the first group of Mental Health First Aid trainers received supplemental training on the Mental Health First Aid for Law Enforcement, Corrections, and Public Safety module. This module builds upon the effectiveness of the standard Mental Health First Aid curriculum by focusing on the unique experiences and needs of law enforcement, corrections and public safety audiences. In June and July 2018, DMH partnered with local Community Mental Health Centers to offer 17 MHFA for Youth trainings to educators across the state free of charge. More than 260 educators participated in these trainings. A federal grant from the Substance Abuse and Mental Health Services Administration in 2018 has enabled DMH to offer mental health training and education to schools and educators throughout the state. Mississippi's Mental Health Awareness Training Project is increasing mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH is partnering with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH will provide training in Mental Health First Aid for Youth to educators and parents. In FY 2017 and FY 2018, Division of Children and Youth Services staff completed four (4) A.S.I.S.T. trainings and six (6) CIT trainings across the state to public schools, law enforcement officers, state agency employees, and institutions of higher learning. Three Division of Children and Youth staff continues to maintain their certification as A.S.I.S.T. Trainers.

Integrated Services for Children and Youth with SED

Initiatives to Assure Transition to Adult Mental Health Services

The Division of Children and Youth Services, the Division of Adult Community Services, and the Division of Alcohol and Drug Services have made a concerted effort to better address issues of youth transitioning from the child to the adult system. The Executive Steering Committee has focused on expanding the age range of children/youth identified as transitional–age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Council has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. DMH currently funds 3 sites that targets transition–aged youth. Most recently, another 4-year grant that targets youth in the child welfare system and/or juvenile justice system was awarded.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services for transitional living programs that address the needs of youth with

SED, including those in the transition age range of 16 to 21 years. DMH continues to provide certification, monitoring, and technical assistance to six (6) transitional therapeutic group homes.

Youth Education/Support Initiatives

Through Crossover XPand and other System of Care programs across the State, Youth Leadership and Advocacy Councils have been developed. These councils meet on a regular basis to plan for fundraising events, community activities, various trainings and independent skill development. Members of these youth councils have attended and presented at national SOC grant meetings, and FFCMH annual conferences and trainings.

Support for Services for Youth with Co-occurring Disorders

The Division of Children and Youth Services partners with the Division of Alcohol and Drug Services to fund and implement Adolescent Intensive Outpatient Programs serving youth with co-occurring disorders utilizing evidence-based practices such as Adolescent Community Reinforcement Approach, Wraparound Facilitation and the GAIN assessment system. Additionally, the Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance use problems which also address problems of youth with co-occurring disorders.

Criterion 4: Targeted Services to Rural and Homeless Populations

Mississippi has the Projects for Assistance in Transition from Homelessness (PATH) Program which provides services to eligible individuals who are experiencing homelessness and have serious mental illness and co-occurring substance use disorders. The focus has been on individuals who are literally homeless, living in places not meant for human habitation. Peer Support Specialists provide street outreach so workers continually interact with people. Peer Support Specialists used lived experience to help homeless individuals believe that getting out of bad situations is possible and that home, employment, and stability are obtainable. The PATH program provides the state with funds for flexible community-based services for persons with serious mental illnesses and co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. DMH provides funding to 4 CMHC's and 1 non-profit provider.

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.

Criterion 5: Management Systems

Federal Block Grant Award FY 2019	
Administration Amount	$298,682
Set Aside	$800,000
Amount to be awarded	$6,272,319
Children's portion	$2,360,006
Adult portion	$2,813,631

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

COMPONENTS OF THE SUBSTANCE USE DISORDERS PREVENTION SERVICE SYSTEM

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

PREVENTION SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

Planning Steps

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

Narrative Question:

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

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

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Step 2: Identification of the Unmet Service Needs and Critical Gaps for Adults and Children

The expansion of community-based services is driven by DMH's Strategic Plan. Since FY10, DMH has utilized a goal-based strategic plan to transform the public mental health system in Mississippi. The *FY19 – FY21 DMH Strategic Plan* includes three goals: To increase access to community-based care and supports through a network of service providers that are committed to a person-centered and recovery-oriented system of care; To increase access to community-based care and supports for people with intellectual and/or developmental disabilities through a network of service providers that are committed to a person-centered system of care; and To ensure people receive quality services in safe settings and utilize information/data management to enhance decision making and service delivery. The Strategic Plan is revised annually and developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan is to create a living, breathing document. The Plan was and continues to be developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies.

The DMH receives feedback through the review of the State Plan by the Mississippi State Mental Health Planning and Advisory Council and the Mississippi Board of Mental Health. The DMH has also benefited greatly from the continuity of its relationship with the Mississippi State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH sends out a statewide satisfaction survey for adults and children as another means of collecting feedback from individuals served by the system. Family members, consumers, local service providers, and representatives from other agencies participate on numerous task forces and coalitions.

In addition to considering estimates of prevalence for targeted groups, results of a statewide consumer survey, public forums, and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing were identified. As part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided the DMH with state level population data and various indicators of poverty and disability. While there continues to be a need for transportation and housing for targeted groups, the information and data provided by TAC has been used on occasions to educate public officials, stakeholders, and funding sources regarding the need for expanding and increasing transportation and housing. The TAC data has also been used to develop applications for funding to increase these services.

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

The Division of Children and Youth Services gains information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, through the work of the

State-Level Interagency Case Review Team, and through SAMHSA funded initiatives in our state.

The Bureau of Behavioral Health Services used the report published by Mental Health America entitled *Mental Health in America 2019 – Ranking the States*, to assist in identifying gaps in our services for adults and children. The report identifies indicators available across all fifty states and the District of Columbia. The report is organized in general categories relating to mental health status and access to mental health services. The data allows the DMH to see how our state is ranked among the other states regarding unmet service needs and gaps within Mississippi's mental health system. Mississippi's rankings are as follows:

- 37th for Adults with highest prevalence of mental illness and lowest rates of access to care (Mississippi
- 11th for Adults with any mental illness (Mississippi: 17.49% National: 18.07%)
- 10th for Adults with serious thoughts of suicide (Mississippi 3.78% National: 4.04%)
- 46th for Adults any mental illness and uninsured (Mississippi: 18.0% National: 12.2%)
- 51st for Adults with Disability who could not see a Doctor due to costs (Mississippi: 30.91% National: 21.62%)
- 46th in mental health workforce availability

The Division of Adult Services within the Bureau of Behavioral Health Services is working To address the needs and gaps noted in the statistics above through the utilization of Mobile Crisis Emergency Response Teams (MCeRT) and Programs of Assertive Community Treatment (PACT), the development of Intensive Community Outreach Recovery Teams ((iCORT), and through the expansion of Crisis Intervention Teams (CIT) across the state.

According to the Behavioral Health Barometer, Mississippi 2017 Report, between 2013-2017, 26,000 Mississippi adolescents, ages 12 to 17 (10.7% of all adolescents) had at least one Major Depressive Episode (MDE). Statistically, Mississippi's data is similar to both the regional average (11.1%) and the national average (12.1%). Approximately 9,000 adolescents, ages 12-17, with Major Depressive Episode (34.4% of all adolescents with MDE in Mississippi) received treatment for their depression, which is similar to both the regional average (38.0%) and the national average (40.3%) during the years of 2013-2017.

During 2013–2017, the annual average prevalence of past-year SMI experienced by young adults in Mississippi (ages 18-25) was 4.1% (or 14,000), similar to both the regional average of 4.8% and the national average of 5.5%. (Behavioral Heath Barometer, 2017).

In, *Mental Health in America 2019 – Ranking the States* (Mental Health America, 2019) the following information is reported on Mississippi's rankings compared to other states:

- 48th for youth ranking with the highest prevalence of mental illness and lowest rates of access to care
- 25th for children with youth with severe Major Depressive Disorder (Mississippi: 8.9% National: 8.7%)

- 5th for youth with at least one Major Depressive Episode (Mississippi: 10.78% National: 12.6%)
- 24th for students identified with Emotional Disturbance for an Individualized Education Program (Mississippi 7.88% National: 7.36%)
- 43rd for children who needed but did not get mental health services (Mississippi: 67.1% National: 61.5%)
- 51st for children reporting inadequate insurance (Mississippi: 21.9% National: 7.8%)
- 46th in mental health workforce availability

Evidenced by the statistics above, access to care is an identified challenge for Mississippi's youth based on the high prevalence rate of emotional and behavioral issues. The DMH has worked diligently to increase the number of qualified providers and to expand services/programs across the state. From January 2011 to September 2018, ten (10) new providers in Mississippi have been certified by DMH to provide the Core Services to children and youth with SED. Fourteen (14) providers are certified to provide Wraparound Facilitation and nine (9) providers are certified to provide Intensive Outpatient Psychiatric Services for Children and Youth with SED, formerly known as MYPAC (Mississippi Youth Programs Around the Clock, a grant funded program initially offered by the Division of Medicaid).

Step 2: Identify the unmet service needs and critical gaps within the current system.
Please describe how MS will meet the gaps and needs within the primary prevention system.

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

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

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

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

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).

According to statistics cited in SAMHSA's *2014-2015 National Survey on Drug Use and Health (NSDUH),* approximately 39.5% of Mississippians age 12 or older were past month alcohol users. This further breaks down 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.

Marijuana

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).

According to statistics cited in SAMHSA's *2014-2015 National Survey on Drug Use and Health (NSDUH),* 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.

Prescription Drug Use

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).

Data driven Decision Making and Needs Assessments Rendered by SEOW

The Bureau of Behavioral Health/Addictive Services, Division of Wellness and Recovery Supports has a State Epidemiological Outcomes Workgroup (SEOW) that was founded in October 2006. This Evidence Based Work Group is spearheaded by The State Epidemiologist and the NPN. One of the many tasks that the SEOW is responsible for is developing and maintaining special task work groups and committees that assist in the **data driven decision making process** that steers all prevention activities in Mississippi. Producing an annual **State Epidemiological Profile** is another key function of the SEOW, as well as, providing all aspect of data collection, analyzing and maintenance for State Level prevention services. It is through these efforts that **Needs Assessments** are rendered by the SEOW at the State Level, by-Region and County Level. All of which have proven to be an essential and effective part of Mississippi's Prevention Infrastructure. This provides for data decision making in the allocation of resources and all areas of focus. Finally, Technical Assistance, Training and Education for the Community Level Service Providers/Sub Grantees are functions carried out by the SEOW that are paramount to the success of the State's Prevention Workforce.

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

Table 1. MS SEOW Member Agencies	
MS Attorney General's Office	MS Department of Education
Army One Source	MS Department of Health, Office of Tobacco Control
Choctaw Behavioral Health	MS Department of Health, Office of Health Data and Statistics
DREAM Inc.	MS Department of Health, Office of Minority Health
DREAM of Hattiesburg	MS Department of Mental Health, BADS
Drug Enforcement Agency	MS National Guard
Independent Evaluators, Univ. of TX-san Antonio	MS PDMP, MS Pharmacy Bureau
Jackson State University, Retiree	Office of Highway Safety
Life Help-Region 6 CMHC	UMMC, Center for Biostatistics and Bioinformatics
Mississippi State University, Social Science Research Center	UMMC, Department of Psychiatry
Mississippi State University	
MS Bureau of Narcotics	

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for the collection, analysis, and reporting of substance use incidence, prevalence, and related data and National Outcome Measures (NOMs). These data are, in turn, used by the State and local communities for

planning, monitoring and evaluation purposes. To fulfill its mission, MS-SEOW uses various archival and real-time data. Data Sources used include but are not limited to:

- Mississippi SmartTrack™ Survey, a web-based data collection tool administered to nealy 125, 000 Mississippi 6th-12th graders.
- DataGadget™ (formerly SURETool), an internet-based software application for reporting of process and outcome data by prevention providers
- National Survey on Drug Use and Health (NSDUH)
- Treatment Episodes Data Set (TEDS)
- Youth Risk Behavior Survey (YRBS) data
- FARS data from the Department of Public Safety

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

etc.).

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

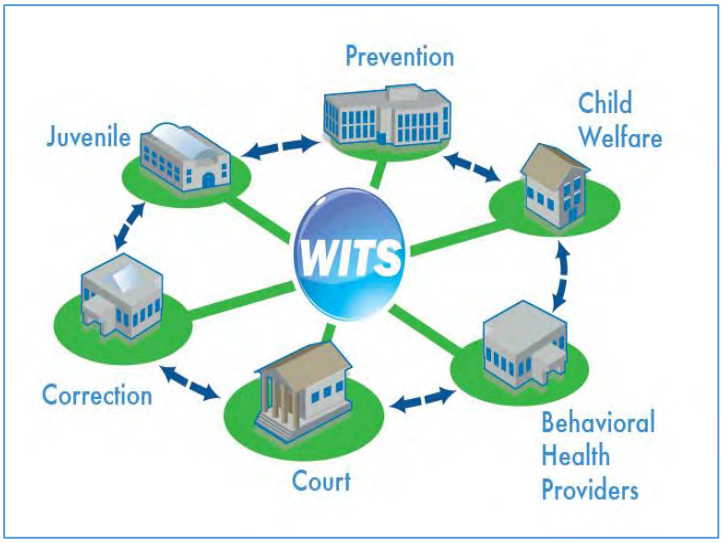
4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Behavioral Health and Related Services

FEi has been focused on Behavioral Health since our inception in 1999. Since that time, we have provided a full range of data collection, case management and reporting solutions to all levels of government, including the ability for states to aggregate data for care coordination and analytics. As new programs, grants, and reporting requirements are introduced by the federal government and private payors, FEi uses its relationships with SAMHSA, CMS, ONC and others to help states proactively prepare for changes that impact behavioral health and social services data and integration.

The majority of FEi's solutions are based on our core platform, called WITS, which is currently used by 29 states and 7 large counties to manage a wide range of behavioral health and related human services data. Each customer installation of WITS is configured to suit the needs of the state or county agency using the system; however, the other features of WITS are still available in a "turned off" mode, which can be enabled at a later date. Many customers begin using WITS for one purpose (i.e., prevention, substance abuse, grant management) and progress to add new features that are needed by the state for management of data or their contracted providers. In many cases, customers also add features to reach new markets or needs. This functionality, once completed, is available to any current WITS customer, typically at a much lower cost than building the functionality from scratch.



WITS can be implemented as:

- Data repository and reporting platform.
- Direct EHR and billing platform for case managers, treatment, recovery or prevention providers.
- Registry or intake/assessment/referral platform (includes many standard assessments including CANS, ASAM, and more).
- Contract and fund management platform with integrated billing.
- Case Management platform for Problem Solving courts and Juvenile Justice.

WITS often integrates with other state systems for data sharing.

SOR Grant: Manage all GPRA data collection; follow up timing and upload directly to SPARS.

Block Grant and TEDS/NOMs: validated and thorough collection of mental health treatment, substance abuse treatment and prevention block grant data; run reporting tables. TEDS/NOMs includes gathering of data into an extract for direct upload to Eagle Technologies. A state-wide waitlist captures access wait times for block grant and state priority populations.

Health Record Features: ROSC model for recovery supports; standardized assessment tools; integrated billing; a full set of clinical management features for substance abuse, mental health, gambling, and prevention. Manage contracts and state funding with an internal claims management system.

Easy access to data: FEi uses an ad-hoc reporting tool that allows non-technical users to query data, and to build, run and schedule reports for any domain or desired data set. This tool leverages the security and user set up from the WITS system, so that providers can run reports on their own data, and the state can see reports for all providers.

Powerful Business Intelligence: FEi recognizes the need for robust data analytics and outcome management based on disparate data sources. FEi has used Microsoft's Power BI, layered on top of the ad-hoc reporting models, to provide dashboards that give users and administrators real-time access to information and data driven decisions. This model also works well with tools such as Tableau.

FEi provides all implementation, training, and ongoing support for WITS. For all but 3 customers, FEi also hosts these systems in an SSAE compliant, secure Equinix facility. Most of our state level implementations have included helping to coalesce the input of various stakeholder groups for better buy-in. The implementation focuses on the desired workflows, as well as the reporting needs of the state, so that users in the field have a workable system that collects solid data for use in reporting and decision making.

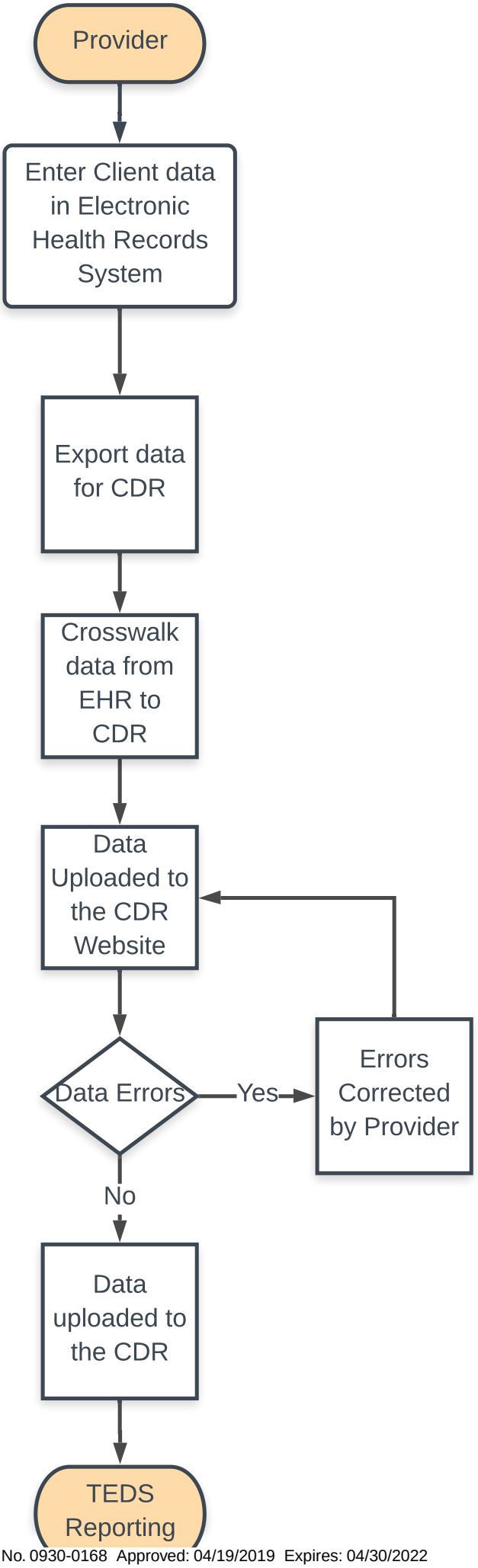
FEi Company Information

FEi's behavioral health experience also extends to the federal level, where FEi has been supporting SAMHSA by providing extensive behavioral health-related technical assistance, application development, training, and mission-critical support. FEi was recently awarded the SAMHSA Behavioral Health Information Technology and Standards (BHITS) contract. This contract serves as SAMHSAs representation in the larger federal Department of Health and Human Services initiative to define information technology (IT) standards for behavioral health to ensure compliance with national and international industry standards.

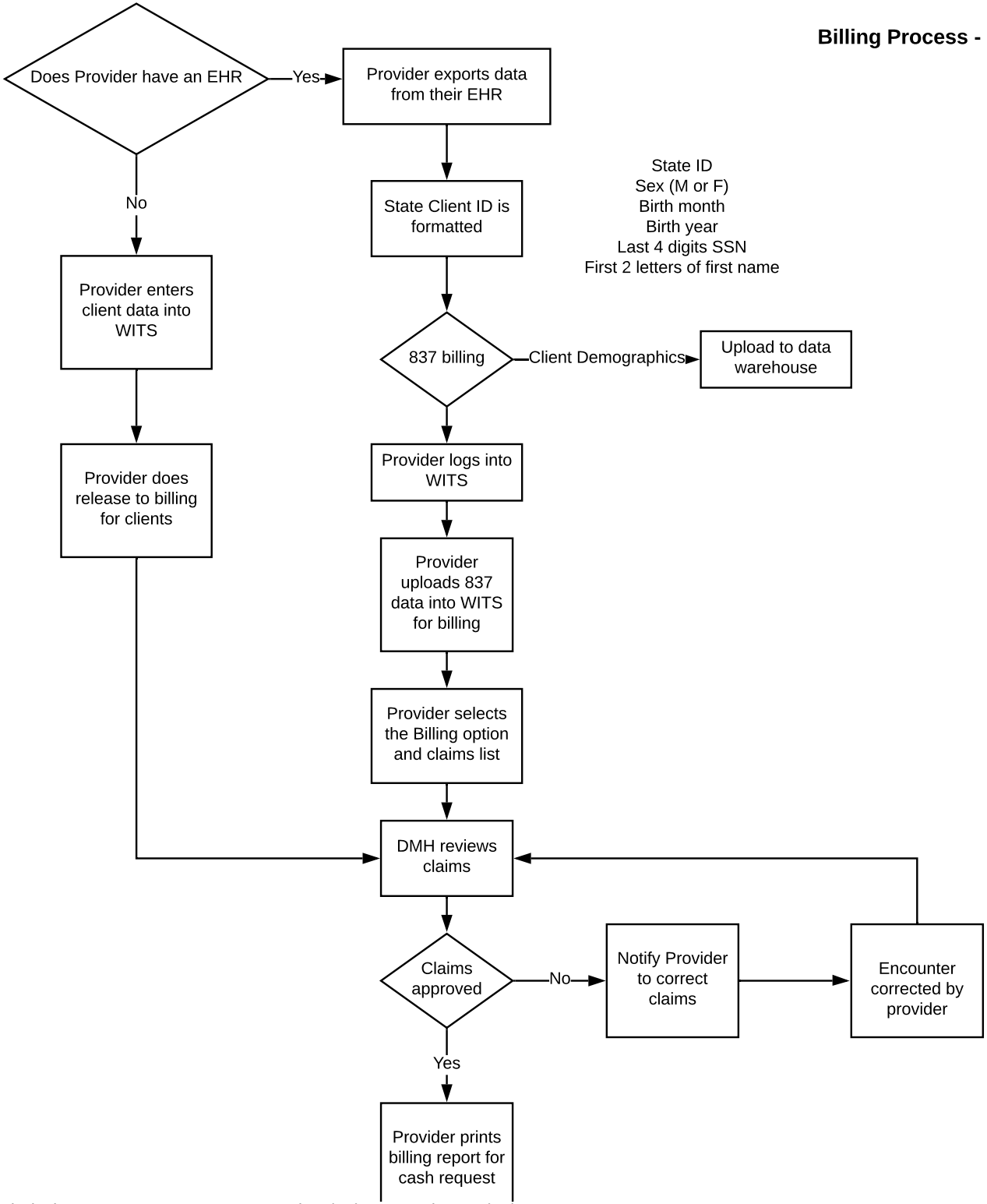
- FEi built SAMHSA's SAIS and TRAC systems, which gather GPRA and other discretionary grant data, and manages an ongoing upload of GPRA data to the SPARS (formerly SAIS) system from WITS, for customers with discretionary grants.
- FEi is currently building the SPARS system for SAMHSA, which will consolidate and update multiple behavioral health data reporting platforms.
- FEi manages SAMHSA's largest funding mechanism through the WebBGAS, which requires extensive and specific knowledge of the design, validations, edits, and technical requirements needed for consistent and successful data exchange between state data systems and the SAMHSA databases.

As a software company serving the needs of state health and human services agencies, FEi also works with three states in the management of Medicaid waiver services. The electronic Long Term Services and Supports System (eLTSS) was designed to give states a centralized web-based application for managing all critical workflow required by Medicaid waivers and programs, and serves the needs of many different client populations including: elderly and disabled, traumatic brain injury, and developmentally disabled. eLTSS is being used for federal rebalancing programs such as Money Follows the Person, Balancing Incentive Payment Program, and Community First Choice.

FEi can provide integration with a health information exchange (HIE), including the implementation of a groundbreaking feature called Consent2Share. Consent2Share sits between an HIE and electronic health records, allowing for the segmentation and sharing of data based on 42 CFR Part 2 compliant consents. Consent2Share is a software application that allows behavioral health patients to determine, through a consent process, which health information they would like to share and not share with their primary and specialty health care providers. Consent2Share integrates with existing electronic health record and health information exchange systems, allowing it to complement rather than replace established channels for information exchange.


Provider
Enter Client data in Electronic Health Records System
Export data for CDR
Crosswalk data from EHR to CDR
Data Uploaded to the CDR Website
Data Errors
Yes
Errors Corrected by Provider
No
Data uploaded to the CDR
TEDS Reporting

Billing Process - Draft



Quality and Data Collection Readiness

The Mississippi Department of Mental Health's current data collection and reporting system is specific to substance abuse and/or mental health services clients. Mississippi is able to collect and report measures at the individual client level with no client-identifying information.

Mississippi currently uses the Central Data Repository (CDR) for data collection and reporting client level data. In 2020, the WITS data warehouse will replace our current CDR and billing process. Currently, the CDR workflow is the current process and is attached. Regarding WITS, the Department of Mental Health has configured WITS for agencies, facilities, programs, services and service rates for certified providers. DMH is working with providers to use WITS for client data entry or to send an interface from the provider's electronic records into WITS. Project completion is scheduled for late Spring 2020. A document with the description of WITS is also attached.

Mississippi SmartTrack School Survey Synopsis

August 2019

Mississippi SmartTrack School Survey
Synopsis

Survey Overview and Significance

Data for the Mississippi SmartTrack School Survey have been collected annually from as many as 125,000 middle school and high school students statewide. Students in grades 6-12 from Mississippi public schools have been the primary survey respondents. At its peak, the survey was conducted in over 80 percent of Mississippi's 82 counties, thereby yielding broad statewide representation. SmartTrack, administered since 2001, has been fielded principally through an online instrument. It has been ideal for tracking trends in youth risk behaviors and attitudes among Mississippi teens. SmartTrack items have been closely aligned with national outcome measures commonly tracked in youth-oriented interventions. The survey has had an excellent item response rate, with valid responses typically collected from over 97% of surveyed students.

One of the most significant advantages of SmartTrack has been large numbers of responses within local communities, thereby permitting prevention workers, grant-writers, and evaluators the ability to detect and address troubling local trends that cannot be discerned with the Youth Risk Behavior Survey and other instruments that have only state-level validity. Due to funding shortfalls, SmartTrack data have not been collected for the past two years, which has left a serious data deficit in the state concerning youth risk factors and drug prevention programming.

Tracking Youth Risk in Mississippi: Select Survey Measures

SmartTrack has had excellent past 30-day and past year drug use items for alcohol, tobacco, and prescription drugs, among many other substances. It has also measured the age at which an array of drugs were first used by young Mississippians. These measures are generally consonant with indicators used on scientifically validated national surveys and federally funded projects featuring national outcome measures. SmartTrack has also featured measures of drug disapproval attitudes and perceived risk of harm.

Beyond drug-related measures, SmartTrack has featured multiple items that gauge risk and protective factors that are critical to understanding the dispositions and behaviors of young Mississippians. Many of risky behaviors perpetrated by youth cluster together, often co-occurring with drug use. Therefore, SmartTrack has posed questions on suicidality (ideation and attempts), mental health (depressive symptoms and anxiety), and highway safety indicators (seatbelt usage, impaired driving, seatbelt law awareness). SmartTrack has also surveyed self-reported school suspensions and expulsions due to alcohol. SmartTrack has permitted researchers to examine the interrelationships between risk factors (drug use, depression, academic failure, etc.). Moreover, the survey has included a host of sociodemographic measures (e.g., age, gender, and race-ethnicity) that permit researchers and prevention workers to track health disparities.

Scientific Rigor and Relevance

SmartTrack has been thoroughly reviewed on an annual basis by Mississippi's Evidence-Based Workgroup to ensure that items of current interest and emerging threats to youth well-being were reflected on the instrument. Mississippi's SmartTrack has approximated a public school student census among participating educational institutions. The survey has provided opportunities to generate profiles of statewide and community prevalence rates, as well as trends across survey years. The large sample size and the high completion rate for SmartTrack have permitted compelling profiles to be generated across communities, time periods, and subgroups of survey respondents. A number of leading Mississippi agencies have contributed to and have regularly used SmartTrack for risk monitoring and surveillance, federal grant proposal writing, and need-based budget allocation to communities throughout the state. Supporting agencies have included the Department of Mental Health, the Department of Education, and the Office of Tobacco Control. The tables that follow provide a snapshot of several frequently utilized SmartTrack measures.

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Table 1. Select SmartTrack Past 30-Day Use Drug Measures
Measure: Past 30-day alcohol use (number of times used): "In the past 30 days, I have smoked, drunk, taken, or used…" [1] beer, [2] wine coolers, [3] other alcohol (each of which is measured separately and can be combined into an alcohol usage index) **Response categories:** 1 = none, 2 = very few times (1-2 times), 3 = a few times (3-9 times), 4 = many times (10-19 times), 5 = very many times (20+ times)
Measure: Past 30-day cigarette use (number of times used) **Response categories:** 1 = none…5 = very many times (20+ times)
Measure: Past 30-day other tobacco use (number of times used) **Response categories:** 1 = none…5 = very many times (20+ times)
Measure: Past 30-day marijuana use (number of times used) **Response categories:** 1 = none…5 = very many times (20+ times)
Measure: Past 30-day other illegal drug use (index of various drugs surveyed separately) (number of times used) **Response categories:** 1 = none…5 = very many times (20+ times)
Measure: Past 30-day prescription drug abuse (number of times used): "In the past 30 days, I have used prescription drugs not prescribed for me by my personal doctor." **Response categories:** 1 = none…5 = very many times (20+ times)
Measure: Binge drinking: "During the past 30 days, on how many days did you have five or more drinks of alcohol in a row, that is, within a couple of hours?" **Response categories:** 0 = 0 days, 1 = 1 day, 2 = 2 days, 3 = 3-5 days, 4 = 6-9 days, 5 = 10-19 days, 6 = 20 or more days

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Table 2. Drug Disapproval Attitudes
Measure: How wrong do you think it is for someone your age to drink beer, wine, or have liquor (e.g., vodka, whiskey, or gin) regularly? **Response categories:** 1 = very wrong, 2 = wrong, 3 = a little wrong, 4 = not wrong
Measure: How wrong do you think it is for someone your age to smoke cigarettes? **Response categories:** 1 = very wrong…4 = not wrong
Measure: How wrong do you think it is for someone your age to smoke marijuana? **Response categories:** 1 = very wrong…4 = not wrong

Table 3. Perceived Risk of Harm
Preamble: How much do you think people risk harming themselves (physically or in other ways) if they:
Measures (four items): Have five or more drinks of an alcoholic beverage or twice a week? **Response categories:** 1 = no risk, 2 = slight risk, 3 = moderate risk, 4 = great risk
Measures (two items): 1/ Smoke one cigarette per day? 2/ Smoke one or more packs of cigarettes per day? 3/ Use smokeless tobacco regularly? **Response categories:** 1 = no risk…4 = great risk
Measures (three items): Smoke marijuana once or twice per week? **Response categories:** 1 = no risk…4 = great risk
Measures: Use cocaine in powder or crack form once or twice per week? **Response categories:** 1 = no risk…4 = great risk

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Table 4. Exposure to Anti-Drug Messages
Measure (parent-child drug harm discussions): During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean your biological parents, adoptive parents, stepparents, or adult guardians—whether or not they live you. **Response categories:** 1 = yes, 2 = no, 3 = don't know or can't answer
Measure (anti-tobacco media exposure): During the past 30 days, how many anti-smoking media messages (television, billboards, posters, magazines) have you seen? **Response categories:** 1 = none (0), 2 = very few (1-2), 3 = a few (3-9), 4 = many (10-19), 5 = very many (20+)

Examples of Other Factors Measured by SmartTrack

- Drug use consequences
  - Driving impaired
  - Riding with an impaired driver
  - Alcohol-related school suspensions and expulsions

- Suicidality
  - Suicide ideation
  - Suicide attempts

- Mental health
  - Depressive symptomology
  - Anxiety

- Safety
  - Seatbelt law awareness
  - Seatbelt usage

- School-based influences
  - Academic performance
  - Extracurricular activity involvement

- Health disparities
  - Age
  - Race-ethnicity
  - Gender
  - County of residence
  - Military family status

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Peer Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance the transition process of individuals to a less restrictive environment

Objective:

Continue to utilize Peer Bridgers to improve the process for people transitioning from inpatient care to community-based care

Strategies to attain the objective:

Utilize Peer Bridgers at a behavioral health program and local Community Mental Health Centers utilizing WRAP

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Peer Bridgers

Baseline Measurement: In FY 2016, there were 5 Peer Bridgers

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 5

Data Source:

Data is collected quarterly by the 3 local CMHCs and the behavioral health program and submitted to DMH.

Description of Data:

Quarterly data collected includes number of Peer Bridgers employed by and tracked by the grantees which are a behavioral health program and 3 local CMHCs. Each of the 3 CMHCs has a full-time Peer Bridger and the behavioral health program has two part-time Peer Bridgers. Services provided by Peer Bridgers will help individuals transition back into their communities and avert future potential crises.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 2

Priority Area: Peer Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Utilize individuals with lived experience of mental illness and/or substance use and parent/caregivers to provide varying supports to assist others in their journey to recovery and resiliency.

Objective:

Increase the number of individuals with lived experience of mental illness and/or substance use and parent/caregivers certified as Peer Support

Specialists (CPSS)

Strategies to attain the objective:

• Conduct outreach to stakeholders to increase the number of CPSS and the role of CPSSs
• Provide training and technical assistance to service providers on the Recovery Model, Person Centered Planning, and System of Care principles
• Provide training to CPSS Supervisors on recruitment, retention, and supervision of CPSSs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number CPSSs employed by DMH certified providers

Baseline Measurement: 36 CPSSs were employed by DMH certified providers in FY 2015

First-year target/outcome measurement: 253

Second-year target/outcome measurement: 278

Data Source:

Data is maintained by DMH based on submission of Verification of Employment Forms to the DMH Division of PLACE.

Description of Data:

Data is collected quarterly from all DMH certified providers employing Certified Peer Support Specialists. In FY 2018, 230 Certified Peer Support Specialists were employed by DMH certified providers.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 3

Priority Area: Community Supports for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements

Objective:

Utilize Programs of Assertive Community Treatment (PACT) Teams to help individuals who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient services

Strategies to attain the objective:

Increase the number of admissions to PACT Teams

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions to PACT Teams

Baseline Measurement: In FY 2015, there were 97 admissions to PACT Teams

First-year target/outcome measurement: 200

Second-year target/outcome measurement: 225

Data Source:

All ten (10) PACT Teams submit data quarterly to DMH. Data includes number of admissions to PACT Team services.

Description of Data:

Quarterly data is submitted by the eight PACT Teams. Data includes number of admissions. During FY 2018, there were 140 new admissions to PACT Teams with 384 individuals being served.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 4

Priority Area: Community Support Services for Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide funding to offset costs of mental health services provided to individuals with serious mental illness who have no payer source

Objective:

Provide services through the Purchase of Services Grant

Strategies to attain the objective:

Grant funding to 14 CMHCs for Purchase of Services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of units of service reimbursed by Purchase of Service Grant

Baseline Measurement: In FY 2015, 180,002 units of service were provided to adults with serious mental illness who have no payer source.

First-year target/outcome measurement: Maintain the number of units of service

Second-year target/outcome measurement: Maintain the number of units of service

Data Source:

The 14 CMHCs submit data monthly through cash requests and monthly reports. This data includes number of units of services provide through the POS grants. Number of units of services reimbursed cannot be increased without an increase in funding.

Description of Data:

Data is collected through monthly cash requests and submitted to DMH by the 14 CMHCs/grantees.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 5

Priority Area: Crisis Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand access to crisis services to divert individuals from more restrictive environments such as jails, hospitals, etc.

Objective:

Expand access to crisis services through the utilization of Crisis Stabilization Units

Strategies to attain the objective:

Track the number of admissions to the Crisis Stabilization Units

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions to CSUs

Baseline Measurement: In FY 2015, there wer 3,609 admissions to the CSUs

First-year target/outcome measurement: 3,500

Second-year target/outcome measurement: 3,600

Data Source:

Quarterly data, which includes number of admissions, is submitted by the CSUs to DMH.

Description of Data:

Crisis Stabilization Units submit data quarterly to DMH which includes the number of involuntary and voluntary admissions. In FY 2018, the CSUs served 3,513 individuals.

Data issues/caveats that affect outcome measures::

With the addition of more CSUs and the implementation of iCORTs, the targets/outcome measurements for the first and second year may differ from the projected targets.

Priority #: 6

Priority Area: Crisis Services

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Divert individuals from more restrictive environments such as jail and hospitalizations by utilizing Mobile Response Teams.

Objective:

Expand access to crisis services through the utilization of Mobile Crisis Response Teams

Strategies to attain the objective:

Increase the number of contacts/calls made by the Mobile Crisis Response Teams

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of contacts/calls

Baseline Measurement: In FY 2015, Mobile Crisis Response Teams received 19,660 calls/contacts

First-year target/outcome measurement: 27,000

Second-year target/outcome measurement: 28,000

Data Source:

The number of emergency calls and contacts responded to by the Mobile Crisis Response Teams is submitted to DMH two times per year.

Description of Data:

Data is submitted two times per year by the Mobile Crisis Response Teams to DMH. In FY 2018, at total of 26,322 calls were received and

there were a total of 18,651 face-to-face visits.

Data issues/caveats that affect outcome measures::

There are currently no issues/caveats expected to affect outcome measures.

Priority #: 7

Priority Area: Supported Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Connect adults with serious mental illness to appropriate housing opportunities

Objective:

Increase the availability of community supports/services for people with a serious mental illness in order to implement Supportive Housing

Strategies to attain the objective:

Ensure that people with a serious mental illness who are housed as a result of Supportive Housing have the opportunity to live in the most integrated settings in the community of their choice by providing an adequate array of community supports/services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of assessments provided; number of individuals maintained in supportive housing

Baseline Measurement: In FY 2016, 48 assessments were provided and 48 individuals were maintained in supportive housing

First-year target/outcome measurement: 200 assessments provided; 200 individuals maintained permanent supportive housing

Second-year target/outcome measurement: 300 assessments provided; 300 individuals maintained permanent supportive housing

Data Source:

The CMHCs operating CHOICE programs submit data quarterly to DMH.

Description of Data:

Data will be submitted quarterly to DMH to include the number of assessments provided and the number of individuals maintained in Supportive Housing. The CHOICE program began in March 2016 with programs being operated by six CMHCs. The CHOICE program is currently available in all CMHC regions, and in FY 2018, 211 assessments were provided. A variety of services are provided to these individuals including outpatient services, peer support, PACT, physician services, community support, intensive case management, and/or psychosocial rehabilitative services .

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 8

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Utilize MAP Teams to help serve children and youth in their community and prevent unnecessary institutionalizations

Objective:

Increase the participation of local representatives from CPS, school districts, and juvenile justice on MAP Teams

Strategies to attain the objective:

Technical assistance will be provided to MAP Team coordinators regarding outreach to increase participation by identified agencies as requested and/or needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of representatives from CPS, school districts, and juvenile justice attending MAP teams quarterly

Baseline Measurement: This is a new indicator. Baseline data will be gathered in FY 2019.

First-year target/outcome measurement: Projections regarding outcomes will be made once baseline data has been gathered

Second-year target/outcome measurement: Projections regarding outcomes will be made once baseline data has been gathered

Data Source:

Data, including local partners present at MAP Teams, are submitted quarterly to DMH by the MAP Team Coordinators.

Description of Data:

Local partners sign-in at each monthly meeting by name and group affiliation or agency represented. Quarterly reports are submitted to DMH by MAP Team Coordinators which compile the information from monthly sign in sheets.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 9

Priority Area: Community Supports for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase statewide use of Wraparound Facilitation with children and youth

Objective:

Increase the number of children served by Wraparound Facilitation

Strategies to attain the objective:

Increase statewide use of Wraparound Facilitation with children and youth through training and supports provided by the Mississippi Wraparound Institute

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children served by Wraparound Facilitation

Baseline Measurement: In FY 2015, 1,078 children were served by Wrapround Facilitation.

First-year target/outcome measurement: 1,775

Second-year target/outcome measurement: 1,800

Data Source:

Data, which includes the number of children and youth served by Wraparound Facilitation, is submitted quarterly to DMH by the Mississippi Wraparound Institute located at the University of Southern Mississippi.

Description of Data:

A total of 12 providers were certified to provide Wraparound Facilitation in FY 2018, and a total of 535 individuals were trained. The Mississippi Wraparound Institute (MWI) employs nationally certified Wraparound coaches in the state to provide training and supports to certified providers of Wraparound Facilitation in Mississippi. Data is submitted quarterly to DMH by MWI. In FY 2018, 1,329 children and youth were served with Wraparound Facilitation.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 10

Priority Area: Community Supports for Children

Priority Type:

Population(s): SED, ESMI

Goal of the priority area:

Assist youth and young adults in navigating the road to recovery from First Episode Psychosis (FEP), including efforts to function well at home, on the job, at school and in the community through the Coordinated Specialty Care Team

Objective:

Increase the number of youth and young adults served through the NAVIGATE Program

Strategies to attain the objective:

Continue an evidenced-based intervention program for youth and young adults who have experienced FEP

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults experiencing FEP served through NAVIGATE

Baseline Measurement: In FY 2016, 4 youth/young adults experiencing FEP were served through by NAVIGATE

First-year target/outcome measurement: 70

Second-year target/outcome measurement: 75

Data Source:

Number of youth and young adults experiencing FEP served through the NAVIGATE Program is submitted monthly to DMH by the two CSC teams.

Description of Data:

NAVIGATE assists individuals, 15-30 years of age, who have experienced their first episode of psychosis. DMH funds the program at Life Help, Hinds Behavioral Health Services, Warren Yazoo Behavioral Health, and Gulf Coast Mental Health Center. In FY 2018, CSC Teams served 23 young adults. Region 8 will begin providing NAVIGATE services in FY 2019. Data is submitted monthly to DMH by the CSC teams which includes the number of youth and young adults served through the NAVIGATE Program.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 11

Priority Area: Community Services for Children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide services through the Juvenile Outreach Program (JOP) that are necessary for a youth's successful transition from a detention center back to his/her home and/or community

Objective:

Decrease the number of re-entries to the detention centers

Strategies to attain the objective:

Continue funding to CMHCs to make mental health services available to youth in detention centers in an effort to prevent re-entries

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth served in detention centers

Baseline Measurement: In FY 2018, 1,760 youth were served in detentions centers in the Juvenile Outreach Program

First-year target/outcome measurement: 1,800

Second-year target/outcome measurement: 1,850

Data Source:

Data is submitted monthly by the CMHCs receiving Juvenile Outreach Program (JOP) grant funding.

Description of Data:

DMH supports 14 Juvenile Outreach Programs to provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center which include immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, and individual therapy. Monthly data is submitted to DMH from the CMHCs receiving grant funding to provide services through the Juvenile Outreach Program. In FY 2018, 1760 youth were served by JOP Programs.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 12

Priority Area: Community Integration

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide community supports for adults transitioning and/or living in the community to prevent out-of-home placements

Objective:

Develop Intensive Community Outreach Recovery Teams (iCORT) for adults with severe and persistent mental illness

Strategies to attain the objective:

Utilize iCORTs to keep people in the community and avoid placement in state hospitals

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of iCORTs operating and number of admissions to iCORTS

Baseline Measurement: Five CMHCs will operate iCORTS. Baseline data regarding number served will be gathered in FY 2020.

First-year target/outcome measurement: 5 iCORTs in operation; Projections regarding outcomes will be established once baseline data has been gathered.

Second-year target/outcome measurement: 5 iCORTs in operation; Projections regarding outcomes will be established once baseline data has been gathered.

Data Source:

Data regarding number of iCORTS operating and number of admissions to iCORTS will be submitted quarterly to the Division of Adult Services.

Description of Data:

Regions 1,2,7,11, and 14 will operate Mississippi's first iCORTS for adults with severe and persistent mental illness to help people remain in the community and avoid placement in state hospitals. The Division of Adult Services will collect the data regarding number served on a quarterly basis from the five (5) CMHCs operating iCORTS.

Data issues/caveats that affect outcome measures::

Baseline data will be gathered in FY 2020. Data issues/caveats that may affect target achievement are currently unknown.

Priority #: 13

Priority Area: Supported Employment

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Develop employment options for adults with serious and persistent mental illness

Objective:

Increase the number of individuals with serious and persistent mental illness who are gainfully employed

Strategies to attain the objective:

Expand employment options for adults with serious and persistent mental illness to employ individuals with serious and persistent mental illness by increasing referrals

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals with SMI who are gainfully employed; Number of referrals made to MDRS

Baseline Measurement: In FY 2016, four (4) program sites helpd 102 individuals become gainfully employed.

First-year target/outcome measurement: 250 individuals employed; 175 referrals made to MDRS

Second-year target/outcome measurement: 300 individuals employed; 180 referrals made to MDRS

Data Source:

Supported Employment programs submit data quarterly to DMH including the number of individuals with serious mental illness who are employed and the number of referrals made to MDRS.

Description of Data:

As of June 2019, supported employment is provided in Regions 2,3,4,7,8,9,10,11,12.14,and 15 These sites submit data quarterly to DMH including the number of individuals with serious mental illness who are employed. In FY 2018, supported employment programs assisted 257 individuals on their road to recovery by helping them to become employed in the openly competitive job market

Data issues/caveats that affect outcome measures::

There are no data issues/caveats expected to affect outcome measures.

Priority #: 14

Priority Area: Recovery Supports

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Strengthen family education and family support capabilities in the state

Objective:

Increase recovery supports to people through family education and family support provided NAMI-MS funded by DMH

Strategies to attain the objective:

Provide a variety of training and workshops targeting people with SMI and family members of children/youth with SED throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of training and workshops

Baseline Measurement: In 2015, 110 workshops/support groups/trainings were conducted by NAMI.

First-year target/outcome measurement: 135

Second-year target/outcome measurement: 140

Data Source:

The number of trainings and workshops provided by NAMI-MS to individuals with SMI and family members of individuals with SMI and children and youth with SED is submitted quarterly to DMH.

Description of Data:

NAMI-MS submits data quarterly to DMH regarding the number of trainings and workshops provided to individuals with SMI and family members of individuals with SMI and children and youth with SED. DMH funds NAMI-MS to provide recovery support services to individuals with serious mental illness and family members of children and youth with SED by offering trainings and workshops on issues surrounding their mental health challenges.

Data issues/caveats that affect outcome measures::

There are no data issues/caveats expected to affect outcome measures.

Priority #: 15

Priority Area: Recovery Supports

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand the peer review/quality assurance process by utilizing Personal Outcome Measures (POM) interviews to measure outcomes of individuals receiving services

Objective:

Improve access and outcomes of services to people receiving services through data gathered in POM interviews

Strategies to attain the objective:

DMH will offer technical assistance to providers after POM reports are released to providers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of visits to conduct POM interviews at CMHCs

Baseline Measurement: In FY 2015 and 2016, 350 POM interviews were conducted during certification visits to the CMHCs.

First-year target/outcome measurement: 8 POM interview visits

Second-year target/outcome measurement: 8 POM interview visits

Data Source:

The number of Personal Outcome Measure (POM) visits to the CMHCs will be tracked and submitted to DMH quarterly.

Description of Data:

The number of Personal Outcome Measure (POM) Interview visits completed during each certification visit to the CMHCs will be tracked and submitted to DMH quarterly. Certified Peer Support Specialists participate on the Certification Visit Team and conduct the interviews during scheduled certification visits. Results of the POM interviews are released to the provider and technical assistance is offered based on the results of the report.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 16

Priority Area: Community Integration

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Enhance the transition process of people to a less restrictive environment

Objective:

Assist individuals in identifying and understanding their personal wellness resources and help them develop a personalized plan to use these resources on a daily basis to manage their mental illness

Strategies to attain the objective:

Strengthen the utilization of Wellness Recovery Action Plans at the behavioral health programs to help individuals identify and understand their personal wellness resources

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Wellness Recovery Action Plans begun prior to discharge from behavioral health programs

Baseline Measurement: In FY 2019, 338 Wellness Recovery Action Plans were begun prior to discharge

First-year target/outcome measurement: 400

Second-year target/outcome measurement: 500

Data Source:

The number of Wellness Recovery Action Plans begun prior to discharge is submitted by the behavioral health programs to DMH on a quarterly basis.

Description of Data:

The number of Wellness Recovery Action Plans begun prior to discharge at the behavioral health programs is submitted quarterly to DMH. Wellness Recovery Action Plans (WRAP) is part of the transition process, which provide people with a self-directed wellness tool upon discharge to support the individual as he/she transitions from a higher level of treatment into a more integrated treatment setting in the community. A total of 338 WRAPs were conducted at the pilot program (NMSH).In addition, SMSH conducted 364 WRAPS.

Data issues/caveats that affect outcome measures::

There are no data issues/caveats expected to affect outcome measures.

Priority #: 17

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide trainings in evidence-based and best practices to a variety of stakeholders

Objective:

Increase the number of parents, school professionals, and School Resource Officers trained in Youth Mental Health First Aid

Strategies to attain the objective:

Offer Youth Mental Health First Aid to school personnel, parents, and School Resource Officers through partnerships with CMHCs and Mississippi Department of Education

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of YMHFA trainings

Baseline Measurement: In FY 2019, 28 YMHFA trainings were offered to parents and school personnel

First-year target/outcome measurement: 45

Second-year target/outcome measurement: 45

Data Source:

Trainings conducted are submitted monthly by certified YMHFA trainers within the DMH and across the state on a monthly basis.

Description of Data:

This data is collected by the Bureau of Outreach and Planning which oversees all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects. Trainings conducted are submitted on a monthly basis by trainers across the state certified in YMHFA.

Data issues/caveats that affect outcome measures::

There are currently no data issues/caveats expected to affect outcome measures.

Priority #: 18

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide trainings in evidence-based and best practices to a variety of stakeholders

Objective:

Increase the number of law enforcement officers trained in Crisis Intervention Team Training

Strategies to attain the objective:

Partner with stakeholders to expand Crisis Intervention Team Training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of officers trained in CIT

Baseline Measurement: In FY 2019, 170 officers were trained in CIT.

First-year target/outcome measurement: 175

Second-year target/outcome measurement: 180

Data Source:

At the conclusion of each CIT Training, a list of graduates is submitted to DMH by the seven counties providing CIT.

Description of Data:

The Division of Adult Services within the Bureau of Behavioral Health Services collects the data from graduation lists submitted by the counties providing CIT. The lists are submitted following each graduation (Desoto County, Jones County, Lauderdale County, Forrest County, Lamar County, Pike County, and Harrison County).

Data issues/caveats that affect outcome measures::

There are no data issues/caveats expected to affect outcome measures.

Priority #: 19

Priority Area: Co-occurring Disorders

Priority Type: SAT

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Determine the co-occurring level of the Community Mental Health Centers (CMHCs) by way of a DDCMHT assessment. (Co-occurring Level will either be Co-Occurring Capable or CoOccurring Enhanced).

Baseline Measurement: In grant year 2017-2018, 0% of the CMHCs Co-Occurring Conditions was identified. In grant year 2018-2019 2 providers were identified as COE.

First-year target/outcome measurement: Provide TA/Training to at least 2 CMHCs that scored lowest on the DDCMHT assessment.

Second-year target/outcome measurement: Provide TA/Training to at least 2 additional CMHCs that scored lowest on the DDCMHT assessment.

Data Source:

DDCMHT Scoring Results

Description of Data:

DDCMHT Scoring Results

Data issues/caveats that affect outcome measures::

Obtaining the by-in from the CMHCs during the re-assessment process.

Willingness of the provider to embrace the changes needed as a result of the DDCMHT assessment.

Priority #: 20

Priority Area: Recovery Supports - Peer Support

Priority Type: SAT

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

To decrease recidivism in Mississippi.

Objective:

Clients will be connected with appropriate peer support specialist (recovery support services) upon discharge.

Strategies to attain the objective:

Recovery support plans will become part of the client record.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Certified Peer Support Specialists by 5%.

Baseline Measurement: Currently there are 90 certified recovery support specialists in the state for SUD.

First-year target/outcome measurement: Increase the number of peer support specialists by 3%.

Second-year target/outcome measurement: Increase the number of peer support specialists by an additional 2%.

Data Source:

Workforce development training database.

Description of Data:

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

Data issues/caveats that affect outcome measures::

None foreseen

Indicator #: 2

Indicator: Increase the overall number of Certified Peer Support Specialists – Recovery

Baseline Measurement: Currently there are 0 Certified Peer Support Specialists- Recovery in the state for SUD.

First-year target/outcome measurement: Increase the number of Certified Peer Support Specialists – Recovery by 2.

Second-year target/outcome measurement: Increase the number of Certified Peer Support Specialists -Recovery by an additional 2%.

Data Source:

Workforce development training database.

Description of Data:

The workforce development division of DMH trains and certifies Peer Support Specialists – Recovery

Data issues/caveats that affect outcome measures::

N/A

Priority #: 21

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Strategies to Obtain the Goal: The Department of Mental Health's (DMH) Bureau of Alcohol and Drug Services (BADS) will continue to certify and provide funding to support fourteen (14) community-based primary residential treatment programs for adult females and males. While all of the programs serve pregnant women, there are two specialized programs that are equipped to provide services for the duration of the pregnancy. Six (6) free-standing programs are certified by the DMH, making available a total of twenty (20) primary residential substance abuse treatment programs located throughout the 14 community mental health regions.
In addition to the substance use disorder treatment, these specialized primary residential programs will provide the following services: 1) primary medical care including prenatal care and childcare; 2) primary pediatric care for their children including immunization; 3) gender specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, parenting, and child care while the women are receiving these services; 4) therapeutic interventions for children in custody of women in treatment which may, among other things address their developmental needs and issues of sexual and physical abuse and neglect; 5) sufficient case management and transportation services to ensure that women and their children have access to the services provided in (1) through (4).

The DMH Operational Standards require that all substance abuse programs must document and follow written policies and procedures that ensure:
• Pregnant women are given priority for admission;
• Pregnant women may not be placed on a waiting list. Pregnant women must be admitted into a substance abuse treatment program within forty-eight (48) hours;
• If a program is unable to admit a pregnant woman due to being at capacity; the program must assess, refer, and place the individual in another certified DMH certified program within 48 hours;
• If a program is unable to admit a pregnant woman, the woman must be referred to a local health provider for prenatal care until an appropriate placement is made;
• If a program is at capacity and a referral must be made, the pregnant woman must be offered an immediate face to face assessment at the agency or 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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of women served who successfully completed treatment.

Baseline Measurement:

First-year target/outcome measurement: Increase by 2% the number of pregnant women who successfully complete treatment during 2019-2020.

Second-year target/outcome measurement: Increase by an additional 1% the number of pregnant women who successfully complete treatment during 2020-2021.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

Funding issues could affect the availability of services.

Priority #: 22

Priority Area: HIV

Priority Type: SAT

Population(s): EIS/HIV

Goal of the priority area:

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

Objective:

To fervently encourage HIV testing, explicitly explain the benefits of HIV testing, provide education pertaining to modes of transmission preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases and tuberculosis, and offer HIV testing immediately after fervently encouraging HIV testing, explicitly explaining the benefits of testing.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Individuals receiving substance use disorder services will know their HIV status and become aware and /or increase awareness of the severity of HIV/AIDS, tuberculosis and sexually transmitted diseases.

Baseline Measurement: Currently there is no baseline, because the data collection began July 2019.

First-year target/outcome measurement: Fifty percent (50%) of individuals in all substance use disorder treatment services will know their HIV status, modes of transmission, preventative measures, accessible community resources and treatment for HIV/AIDS, sexually transmitted diseases and tuberculosis.

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

Data Source:

MS Department of Health STD/HIV Office-Prevention Branch

Description of Data:

An HIV Early intervention Services Reporting Form will be completed by all substance use disorders providers monthly to report data to the Mississippi Department of Health. The Mississippi Department of Mental Health, Bureau of Behavioral Health/Addictive Services will receive a yearly summary.

Data issues/caveats that affect outcome measures::

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

Priority #: 23

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

All DMH certified substance abuse programs must document and follow written policies and procedures that ensure:
A. Individuals who use IV drugs are provided priority admission over non-IV drug users.
B. Individuals who use IV drugs are placed in the treatment program identified as the best modality by the assessment within forty-eight (48) hours.
C. If a program is unable to admit an individual who uses IV drugs due to being at capacity, the program must assess, refer and place the individual in another certified DMH program within forty-eight (48) hours.
D. If unable to complete the entire process as outlined in sectioned C., DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place an individual who uses IV drugs cannot exceed forty -eight (48) hours from the initial request for treatment from the individual.
E. If a program is at capacity and a referral must be made, the referring provider is responsible for assuring the establishment of alternate placement at another certified DMH program within forty-eight (48) hours.
F. The referring provider is responsible for ensuring the individual was placed within forty-eight (48) hours.
G. In the case there is an IV drug user that is unable to be admitted because of insufficient capacity, the following interim services will be provided:
1. Counseling and education regarding HIV, Hepatitis, and TB, the risks of sharing needles, the risk of transmission to sex partners and infants, and the steps to prevent HIV transmission; and
2. Referrals for HIV, Hepatitis, and TB services made when necessary

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of IV drug users successfully completed treatment.

Baseline Measurement: 393 IV drug users complete treatment

First-year target/outcome measurement: Increase by 3% the number of IV Drug Users who successfully complete treatment after admission.

Second-year target/outcome measurement: Increase by 3.5% 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:

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

Data issues/caveats that affect outcome measures::

None foreseen

Priority #: 24

Priority Area: Prescription Drug Use

Priority Type: SAP

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

Goal of the priority area:

To reduce the number of prescriptions and dosage units.

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adolescent Past 30 Day Prescription Drug Use

Baseline Measurement: 3.4% of 6-11th graders report using prescription drugs that were not prescribed to them by

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

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

Data Source:

Smarttrack

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

Indicator: Perception of Harm

Baseline Measurement: In 2016, 3.4% of Mississippi youth in grades 6-11 reported having used prescription drugs

First-year target/outcome measurement: Reduce the baseline prevalence estimate of youth in grades 6-11 that report having usedprescription drugs in a way other than how they were prescribed by .5% during the first year

Second-year target/outcome measurement: Reduce the baseline prevalence estimate of youth in grades 6-11 that report having usedprescription drugs in a way other than how they were prescribed by 1% during the second

Data Source:

SmartTrack

Description of Data:

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

Data issues/caveats that affect outcome measures::

None foreseen

Priority #: 25

Priority Area: Alcohol Use

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adolescent Past Month Alcohol Use

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

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

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

Data Source:

NSDUH

Description of Data:

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

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

Data issues/caveats that affect outcome measures::

None foreseen

Indicator #: 2

Indicator: Young Adult Past Month Alcohol Use

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

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

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

Data Source:

NSDUH

Description of Data:

NSDUH Description: The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco,

alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

Data issues/caveats that affect outcome measures::

None

Priority #: 26

Priority Area: Marijuana Use

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Reduce past 30 days use among 12-17 year olds

Strategies to attain the objective:

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adolescent Past Month Marijuana Use

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

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

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

Data Source:

NSDUH

Description of Data:

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

Data issues/caveats that affect outcome measures::

None Foreseen

Indicator #: 2

Indicator: Young Adult Past Month Marijuana Use

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

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

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

Data Source:

NSDUH

Description of Data:

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

Data issues/caveats that affect outcome measures::

None expected

Priority #: 27

Priority Area: Responding to the Opioid Crisis

Priority Type: SAT

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 5 certified OTP's in the state.

First-year target/outcome measurement: 2 additional providers will be certified in the state.

Second-year target/outcome measurement: 2 additional providers will be certified in the state.

Data Source:

Certification database

Description of Data:

The Certification database contains all certified providers and their certifications.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$9,663,977		$0	$0	$0	$0	$0
a. Pregnant Women and Women with Dependent Children**	$0		$0	$0	$0	$0	$0
b. All Other	$9,663,977		$0	$0	$0	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$2,761,136		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$690,284		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$690,284		$0	$0	$0	$0	$0
10. Total	**$13,805,681**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

* Prevention other than primary prevention

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

Footnotes:

These are the State's Planned Expenditures for SA in accordance to the FY 19 Final Award amount.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$229,425	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$800,000	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$10,000,000	$6,500,000	$75,000,000	$0	$10,000,000
7. Other 24 Hour Care		$0	$8,000,000	$0	$26,256,489	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$4,944,212	$140,000,000	$3,261,540	$25,277,980	$0	$0
9. Administration (Excluding Program and Provider Level)***		$298,682	$0	$100,000	$1,780,000	$0	$25,000
10. Total	**$0**	**$6,272,319**	**$158,000,000**	**$9,861,540**	**$128,314,469**	**$0**	**$10,025,000**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	420
2. Women with Dependent Children	0	117
3. Individuals with a co-occurring M/SUD	0	404
4. Persons who inject drugs	0	2039
5. Persons experiencing homelessness	0	493

Please provide an explanation for any data cells for which the state does not have a data source.
Mississippi do not have a system that tallies the number of individuals in need (on wait-list), at this time. Therefore Mississippi estimates the number of individuals in need for FY 19 to be about the same as the number of individuals served during calendar year 2018.
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$9,661,332
2 . Primary Substance Abuse Prevention	$2,760,380
3 . Early Intervention Services for HIV**	$690,095
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$690,095
6. Total	**$13,801,902**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$670,686
	Selective	
	Indicated	
	Unspecified	
	Total	**$670,686**
2. Education	Universal	$841,804
	Selective	$66,881
	Indicated	
	Unspecified	
	Total	**$908,685**
3. Alternatives	Universal	$274,769
	Selective	
	Indicated	
	Unspecified	
	Total	**$274,769**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	$156,589
	Unspecified	
	Total	**$156,589**
	Universal	$313,178

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$313,178**
6. Environmental	Universal	$160,628
	Selective	
	Indicated	
	Unspecified	
	Total	**$160,628**
7. Section 1926 Tobacco	Universal	$78,689
	Selective	
	Indicated	
	Unspecified	
	Total	**$78,689**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$2,563,224**
Total SABG Award*		**$13,801,902**
Planned Primary Prevention Percentage		**18.57 %**

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

The MHBG Coordinator created a joint application in error. The SABG Coordinator will finalize this Table by October 1, 2019.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$1,318,196
Universal Indirect	$1,004,514
Selective	$84,505
Indicated	$156,009
Column Total	**$2,563,224**
Total SABG Award*	**$13,801,902**
Planned Primary Prevention Percentage	**18.57 %**

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

The MHBG Coordinator created a joint application in error. The SABG Coordinator will finalize this Table by October 1, 2019.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

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

Footnotes:

The MHBG Coordinator created a joint application in error. The SABG Coordinator will finalize this Table by October 1, 2019.

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$100,000	$37,909	
2. Infrastructure Support	$50,000	$51,338	
3. Partnerships, community outreach, and needs assessment			
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education		$107,909	
8. Total	**$150,000**	**$197,156**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

? Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $ 197156.

? Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $0.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FFY 2020 Block Grant
1. Information Systems	
2. Infrastructure Support	
3. Partnerships, community outreach, and needs assessment	
4. Planning Council Activities (MHBG required, SABG optional)	
5. Quality Assurance and Improvement	$50,000
6. Research and Evaluation	
7. Training and Education	$180,000
8. Total	**$230,000**

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

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

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

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

January 2019 DMH was awarded the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant Project from the Department of Health and Human Services- Substance Abuse and Mental Health Services Administration to promote collaborative partnerships with local primary healthcare organizations and mental health clinics. The goal of the project is to fully integrate and collaborate mental health and primary healthcare in two of Mississippi's most prominent cities, the capitol city of Jackson (Hinds County) and the Hub City of Hattiesburg (Forrest County). This project directly aligns with the inclusion and integration of clinical practices between primary and behavioral healthcare services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings. Evidenced based practices will be utilized to achieve goals to: (a) increase holistic care capacity, (b)promote coordinated care, (c) identify behavioral and physical health concerns early, (d) facilitate communication and collaboration between health care providers, and (d) improve patient education, satisfaction and outcomes. Additionally, DMH ensures full integration of services through collaboration with fully staffed partners and multidisciplinary teams in the primary healthcare settings and the local mental health centers to provide cost effective services.

Formerly, integrated mental health, substance use and primary health care services were not all available at the same location on a statewide basis. However, in 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care. IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc. Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care. Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of

Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association. Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue. In 2011, 2012, 2015, and 2017 DMH submitted grant applications to SAMHSA and CMH to develop initiatives to integrate mental health and primary healthcare. Although none of these grant applications were successful, the opportunities for collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

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

A representative from the Department of Health and the Division of Medicaid are among child and family service agencies participating on the State-Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) Teams across the state. As part of their application to the DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services. DMH has facilitated incorporation of practices and procedures that promote a philosophy of recovery/resiliency across Bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Providers. The DMH Division of Alcohol and Drug Services continues to work with the Attorney General's Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner. The DMH Division of Alcohol and Drug Services partners with the MS Department of Rehabilitation Services to fund substance use treatment services to individuals in transitional residential programs. The DMH Division of Alcohol and Drug Services works collaboratively with the MS Band of Choctaw Indians and continue to fund prevention services with Choctaw Behavioral Health. The DMH Division of Alcohol and Drug Service has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. Through this partnership, trainings are provided around the state. The training is also available for A&D personnel located at community mental health centers. The DMH Bureau of Behavioral Health Services' Annual Provider Survey gathers self-reported information on integrated primary and behavioral health care, as well as on tele-medicine opportunities. In December 2014, the DMH Bureau of Behavioral Health Services and the DMH Bureau of Outreach, Planning and Development applied for and were awarded membership in the SAMHSA-HRSA Center for Integrated Health Solution's (CIHS) Innovation Community entitled Building Integrated Behavioral Health in a Primary Care Setting. This collaboration is between the DMH, a local CMHC, and a local FQHC. In March 2015, the DMH Division of Recovery and Resiliency applied for and was awarded a 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Subcontract for the Expansion of Policy Academy Action Plans. In October 2016, the Department of Mental Health partnered with the Department of Health and the Mississippi Public Health Institute for a State Forum on Integrated Care. One of the outcomes of the forum was to develop a document to help guide integrated care in Mississippi as we move forward. The Roadmap for Integrated Care in Mississippi has been completed and is now available. Forum participants developed practical strategies for innovative health system transformation as detailed in the action plan in Section III of the document. These components will serve as the foundation for the Roadmap to Integrated Care in Mississippi. DMH's Integration Work Group served as the advisory committee for the State Forum event.
DMH's Integration Work Group is a multidisciplinary, interagency work group which was created in August 2011 for the purpose of developing strategies and partnerships to facilitate the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care to create a holistic approach to care. In addition, the DMH has funded the development of PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). Health information is obtained for all individuals seeking services from the DMH certified providers on the Initial Assessment. A medical examination is required for individuals in supervised and residential programs, as well as in senior psychosocial programs. Also, Certified Peer Support Specialists are trained to assist individuals receiving services in accessing all health care services. Four Community Mental Health Centers report working directly with their local Community Health Center to provide primary care and other medical services; two of those Community Mental Health Centers have a formal agreement with the Community Health Center. One Community Mental Health Center reports that they provide primary health care services at the CMHC. Lifecore/ Region 3 Mental Health Center located in Tupelo, Mississippi, serves seven counties and is a comprehensive health system. The main center in Tupelo is a ten thousand square foot building devoted to the co-location and integration of primary health care and behavioral health care services. Included in this facility is a pharmacy which provides both medical and psychotropic medication for all its clients. Additionally, Region 3 operates a mobile primary care unit which travels to four counties in its region.

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

b) and Medicaid? ○ Yes ◉ No

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

The Mississippi Department of Health

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

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ○ Yes ◉ No

b) Health risks such as

ii) heart disease ○ Yes ◉ No

iii) hypertension ○ Yes ◉ No

iv) high cholesterol ○ Yes ◉ No

v) diabetes ○ Yes ◉ No

c) Recovery supports ◉ Yes ○ No

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

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

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

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

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

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

Please indicate areas of technical assistance needed related to this section

none

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes	( ) No
b) Ethnicity	(•) Yes	( ) No
c) Gender	(•) Yes	( ) No
d) Sexual orientation	( ) Yes	(•) No
e) Gender identity	( ) Yes	(•) No
f) Age	(•) Yes	( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (•) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (•) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

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

All DMH certified providers are required to develop and implement policies and procedures that address Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Hunan Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. The Cultural Competency Plan Implementation Workgroup recommended inclusion of language and proficiency in the DMH data collection standards including questions regarding primary language spoken by the individual, language preferred by the individual, language written by the individual, and whether or not the individual receiving services needed an interpreter. Due to funding constraints, the Workgroup was informed that additional questions to the current data collection system are currently not possible. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible. The current DMH Central Data Repository does not address or track language needs. Language needs are addressed by creating a comprehensive list of translators and interpreters in Mississippi as well as a list of resources for alternate forms of communication for individuals with hearing, visual and/ or other disabilities. These two lists have been mailed to programs to assist with providing language needs. The state has a State Plan for Cultural Competency, which includes workforce-training. The state provides trainings on cultural competence, CLAS standards, and cultural diversity to DMH certified providers. The CLAS Standards trainings are conducted upon request and the trainings have been conducted at statewide conferences. Due to budget reductions during recent legislative sessions in our state, technical assistance is needed regarding innovative ways to assist mental health providers in the implementation of CLAS Standards with limited funds.

Please indicate areas of technical assistance needed related to this section

none

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

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

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

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

none

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

none

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4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The five programs operated by Region 6, Region 8, Region 9, Region 13, and Region 15 CMHCs utilize the evidence-based practice, NAVIGATE a Coordinated Specialty Care (CSC) model created under the RAISE initiative for First Episode Psychosis (FEP). DMH contracts with NAVIGATE consultants, Susan Gingerich, Shirley Glynn, and Corrine Cather to provide training and technical assistance to the five CSC teams. Two-day intensive trainings have been provided to the NAVIGATE CSC Teams specifically focusing on the roles of the Individual Resiliency Training (IRT) clinicians, the Supported Employment/Education (SEE) specialists, and the Family Education clinicians. The NAVIGATE consultant team continues to provide bi-monthly technical assistance telephone calls to review roles, manuals, discuss youth referred, and provide input and guidance on further program development.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

DMH funds, promotes and supports the five NAVIGATE programs described above. The NAVIGATE curriculum and model includes

individualized treatment, service plans, and coordination with physical health services.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

NAVIGATE is a comprehensive treatment program for people who have had a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and get their life back on track. More broadly, NAVIGATE helps clients navigate the road to recovery from an episode of psychosis, including getting back to functioning well at home, work, and in the social world. NAVIGATE includes four different treatments: individualized medication treatment, family education, individual resiliency training, and supported employment and education.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Planned activities include providing education and information on the NAVIGATE Program at community events and local referral agencies in the areas served by the five (5) programs. DMH plans to facilitate an on-site training for new CSC team members as well as continue monthly technical assistance calls with the NAVIGATE consultants.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state collects data quarterly from Regions 6, 8, 9, 13 and 15. Data collected includes intakes and number enrolled, number of individuals maintained in the community, utilization of emergency rooms or psychiatric hospitalization, employment status and hours worked, school enrollment, types of services provided, and number of contacts with NAVIGATE staff.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic categories identified for Mississippi's ESMI programs are the disorders classified in the DSM -5 as Schizophrenia Spectrum and Other Psychotic Disorders which include Schizophrenia, Schizoaffective Disorder, and Schizophreniform Disorder.

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

none

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Consumers and caregivers are involved in making health care decisions and guiding the treatment and recovery process through Wraparound Facilitation, Peer Support Services, Wellness Action Recovery Plans and Individual Action Recovery Plans, and Personal Outcome Measure (POM) interviews. During Personal Outcome Measure (POM) interviews, individuals are asked about preferences including dreams and goals. Individuals are asked to describe their dreams and goals. In turn, providers are questioned as to how they are supporting individuals to achieve their stated dreams and goals. Regarding the 25 Quality of Life Measures, individuals are asked if they possess these qualities in their lives, and if so, are they satisfactory. The Initial Assessment utilized by all DMH certified providers has been redesigned to reflect this change.

4. Describe the person-centered planning process in your state.

The Department of Mental Health is making great progress in transforming Mississippi's public mental health system into one that is person-centered and recovery-oriented. The Initial Assessment and Individual Service Plans utilized by DMH certified providers have been redesigned and now require clinicians to record individuals' hopes, dreams, and goals in the individuals' own words. Training is being provided across the state to providers to enforce the importance of the person-centered and recovery-oriented process. In addition, during Personal Outcome Measure (POM) interviews, individuals are asked about their dreams and goals. In turn, providers are asked how they are supporting the individuals in achieving their stated dreams and goals. For each individual receiving services, the 25 Quality of Life Measures are examined to determine the individual's satisfaction with their own quality of life.

In Mississippi, high-fidelity Wraparound Facilitation is provided to engage children and youth and their caregivers in decisions made regarding their mental health care. A key element of Wraparound Facilitation is that of family determination which means the family's perspective, preferences and opinions are first, understood; second, considered in decision making; and finally, influential in how the team makes decisions. Activities include assembling the child and family team according to the child and caregiver's preferences, facilitating a child and family team meeting at a minimum every thirty (30) days, facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, working with the team in identifying providers of services and other community resources to meet family and youth needs, and monitoring the implementation of the plan of care and revising if necessary to achieve outcomes. DMH currently certifies twelve (12) providers in the state to provide Wraparound Facilitation. Mississippi has nationally certified Wraparound Coaches that provide training and support through the Mississippi Wraparound Institute at the University of Southern Mississippi. In FY 2018, 1,329 children and youth were served with Wraparound Facilitation.

Peer Support is a helping relationship between peers and individuals and/or family members that is directed toward the achievement of specific goals defined by the individual. Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery.

Individuals participating in Psychosocial Rehabilitation Programs offered through the CMHCs are required to have an Individual Recovery Action Plan (IRAP) or Wellness Recovery Action Plan (WRAP). WRAP and IRAP plans are developed by the individuals and

involve setting their own goals and assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths, knowledge and needs in the individual's living, learning, social, and working environments.

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

none

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

Specific grant requirements are conveyed to Department of Mental Health service providers during the RFP process. Additionally, service providers are required to sign a packet of applicable agreements including both a list of “Federal Assurances” and Mississippi Department of Mental Health Assurances on an annual basis. Any additional requirements specific to grant funding are included in this annual packet to be signed by the program administrator annually. Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not meet the programmatic intention of the grant funds or do not meet the “necessary and reasonable” test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise.

The Department of Mental Health has an Audit Division with two major functions:
1) Conduct annual compliance audits of grant sub-recipients. Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc. Audit procedures are outlined in the agencies “Central Office Audit Guide.”
2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines,

reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies “Service Providers Manual” that is available on-line on the Mississippi Department of Mental Health website.

The Division of Certification is responsible for provider certification across the three populations served by the DMH – mental health, intellectual/developmental disabilities, and substance use. The DMH operates on a three year certification cycle to ensure that all DMH certified providers have an on-site compliance/certification visit at a minimum of twice during that certification cycle. In addition to the on-site compliance visits, the DMH regularly conducts visits to certified providers to certify additional new programs and services. The DMH does institute a CQI process as part of its monitoring. As issues of noncompliance regarding health, safety, and programmatic standards are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues and maintain ongoing compliance. Providers develop and submit plans of compliance to the DMH for approval and subsequent implementation. In turn, the DMH conducts follow up visits to ensure that corrective action is taken and remains ongoing. The DMH tracks all deficiencies to identify trends and patterns and make changes to policy as needed

Please indicate areas of technical assistance needed related to this section

none

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

There have been no consultation sessions involving DMH and the MS Band of Choctaws. Please see the response to Question 3. to discover collaboration efforts between the Mississippi Department of Mental Health and the Mississippi Band of Choctaw Indians.

2. What specific concerns were raised during the consultation session(s) noted above?

There have been no consultation sessions involving DMH and the MS Band of Choctaws.

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

The DMH Bureau of Behavioral Health Services works collaboratively with the MS Band of Choctaw Indians and continues to certify and fund substance us prevention services with Choctaw Behavioral Health. The Department of Mental Health continues to have an individual from the Choctaw Tribe participating on the Multicultural Task Force. The Director of Choctaw Behavioral Health serves on the planning committee for the Annual Statewide Trauma Informed Care Conference. She ensures sessions are inclusive of issues relating to staff and individuals receiving services at their agency. The MS Band of Choctaw Indians has representation on the MS Mental Health Planning and Advisory Council.

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

none

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8. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

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

☑ Archival indicators (Please list)

SmartTrackTM (www.thesmarttrack.com) is the leading provider of internet data collection and dissemination services for school-based prevention needs-assessment survey. Since 2001, approximately 1.2 million middle school and high school students have completed an online survey using the SmartTrack system. SmartTrack has supported statewide internet survey projects in Mississippi. In addition, numerous school districts and counties in the state of Mississippi have used SmartTrack.

• 2001-2015 Mississippi SmartTrack Survey – Data collected from an average of 115,000 students per year, from over 400 schools in 100 districts.

☑ National survey on Drug Use and Health (NSDUH)

☑ Behavioral Risk Factor Surveillance System (BRFSS)

☑ Youth Risk Behavioral Surveillance System (YRBS)

☑ Monitoring the Future

☑ Communities that Care

☑ State - developed survey instrument

☑ Others (please list)

Items in the SmartTrack survey are drawn from established, science-based, national or researched youth surveys, such as the Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control and Prevention (CDC). Survey questions on ATOD use and attitudes are drawn directly from the battery of measures identified by the Center for Substance Abuse Prevention (CSAP) for evaluating youth prevention programs as required by the Government Performance and Results Act (GPRA). As such, the survey items, as administered by Public Schools, draw their validity from the most prestigious (and valid) of national data standards and tools. Research documentation will be provided upon request.

The information collected by this survey is based entirely on the truthfulness, recall, and comprehension of the youth who participated in the survey. Many studies have shown that most adolescents are truthful in their responses to the questions on similar surveys. For example, ATOD trends for repeated national and state surveys are very similar. Finally, the relationships between different kinds of behaviors and the problems adolescents report is very consistent over a wide range of studies. All survey items were carefully designed to ensure honest responses from participants.

The confidentiality of the survey was stressed through the instructions and administration procedures. Participants were to be assured that the survey was voluntary, anonymous, and confidential, told that no one would see their answers, and that there was no way that a survey could be traced back to an individual student. Because the survey was anonymous, most of the reasons to exaggerate or deny behaviors were eliminated. However, several checks were built into the analysis to minimize the impact of students who were not truthful in their responses. Students whose surveys were deemed not truthful, via a student-reported claim to use a nonexistent drug, were eliminated. Also, surveys in which more than 40% of items were unanswered were eliminated.

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

If yes, (please explain)

The Bureau of Behavioral Health/Addictive Services, Division of Wellness and Recovery Supports has a State Epidemiological Outcomes Work group (SEOW) that was founded in October 2006. This Evidence Based Work Group is spearheaded by The State Epidemiologist and the NPN. One of the many tasks that the SEOW is responsible for is developing and maintaining special task work groups and committees that assist in the data driven decision making process that steers all prevention activities in Mississippi. One of these special task work groups is the Evidenced Based Work group. It was established in 2008. One of its primary functions is to support the SEOW/Epi in ensuring data driven decision making. This work group steers the allocation of resources, determines the priorities in which to focus, as well as influence the distribution of funding by areas of need and geography. Producing an annual State Epidemiological Profile is another key function of the SEOW, as well as, providing all aspect of data collection, analyzing and maintenance for State Level prevention services. It is through these efforts that Needs Assessments are rendered by the SEOW at the State Level, by-Region and County Level. All of which have proven to be an essential and effective part of Mississippi's Prevention Infrastructure. This provides for data decision making in the allocation of resources and all areas of focus. Finally, Technical Assistance, Training and Education for the Community Level Service Providers/Sub Grantees are functions carried out by the SEOW that are paramount to the success of the State's Prevention Workforce.

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

Narratve Question

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

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

Capacity Building

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

If yes, please describe

The Department of Mental Health has an addition certification with the requirements of a masters degree in a related field of study and two years of direct experience in alcohol drug field. The Mississippi Association for Addiction Professionals (MAPP) maintains a certification for substance use disorder prevention workforce, including prevention specialist.

The Mississippi Association of Addiction Professionals has designated this credentialing system which evaluates competency and grants recognition only to those who meet specified minimum standards. It certifies the functions, responsibilities, knowledge, and skill base required by prevention professionals in the performance of their jobs.

In creating this system, MAAP attempted to ensure a broad representation of the prevention disciplines. There has been a new emphasis on prevention in health care, and we are in an era of growth and change, which provides a time for unification and which requires definition.
Associate Prevention Specialist, Certified Prevention Specialist and Certified Prevention Specialist Manager are the three types of certifications available.

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

If yes, please describe mechanism used

The Mississippi Department of Mental Health, Bureau of Behavioral Health/Addictive Service (DMH) has awarded a Workforce Development Contract to the nonprofit organization The Mississippi Public Health Institute (MSPHI).
- Workforce Development training provided through the Mississippi Public Health Institute
- Training is free to DMH-certified providers ($25.00 for non-certified)
- Online and in-person
- MOU with the Mississippi State Dept. of Mental Health to provide training in best practices related to substance use disorders
o Prevention Ethics
o Language of SUD Prevention
o HIV/AIDS Education and Awareness
o Substance Abuse Prevention Skills Training (SAPTS)
o Narcan (naloxone) use as a preventative measure to death by overdose

Substance Abuse Block Grant (SABG):
The Mississippi Behavioral Health Learning Network (MSBHLN) was established by the Mississippi Public Health Institute (MSPHI) in

July 2017 in a partnership with the Mississippi Department of Mental Health, Bureau of Behavioral Health/Addictive Services (MSDMH BBHAS) to provide professional and workforce development within the State's Prevention Workforce.

Mission
MSPHI is dedicated to the progress of Mississippi's Prevention Services Workforce by providing evidence-based, relevant and effective training and professional development opportunities.

Vision
Building the workforce to move Mississippi's Prevention Infrastructure forward utilizing CSAP's Strategic Prevention Framework and Data Driven Decision Making.

Training Program
The trainings developed by the MSPHI are designed to help prevention professionals gain a better understanding of substance abuse prevention and substance use disorder treatment, assist with acquisition of current strategies and to provide participants with the knowledge, skills and attitudes to effectively and efficiently perform the responsibilities of their jobs.

MSPHI training offers an assortment of relevant and current training modules applicable to the Prevention Services. In addition to the in-person training, MSPHI offers an online training network through web-based training, webinars and self-paced learning modules. In addition, many of the training modules provide continuing education credits that assist prevention specialist in obtaining their prevention certification via the Mississippi association of Addiction Professional.

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

If yes, please describe mechanism used

Narratve Question

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

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

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

In 2018, The Bureau of Behavioral Health/Addictive Services Division of Wellness and Recovery Supports developed a preliminary strategic plan in efforts to promote a universal approach to prevention services in Mississippi. It is through the joint efforts of the SABG and the (mPACC) discretionary grant that the guidelines for the State's entire prevention infrastructure could be unified and sustainable. The requirements of all prevention services in Mississippi established in the strategic plan are listed below;

Requirements of Substance Abuse Prevention in Mississippi includes conducting Primary Prevention activities only. Prevention services are not to be conducted at detention centers. Prevention services are not to be used for populations that are already using substances and require treatment.

40% of Prevention activities must consist of environmental strategies. SABG Prevention programs must work towards passing at least one ordinance in their service area.

SABG Prevention programs must conduct environmental strategies that will impact every individual within their catchment area.

40% of Prevention activities must consist of Prevention education using an Evidenced-Based Policies, Practices, and Programs (EBP's).

Prevention funds are to be used to purchase curriculums for EBPs that are used in the schools. Making copies of trademarked EBP's materials are a violation of copyright laws. There should be a line item in your budget and narrative that demonstrates the use of funds for purchasing curriculums. If your agency has decided to use a free curriculum, please attach documentation that indicates the terms and conditions for the use of the curriculum. Two Prevention Specialists should not implement the same EBP in the same classroom simultaneously, unless a new Prevention Specialist is being trained for a brief period. For Prevention services to be delivered in schools, teachers must be present in the classrooms alongside the Prevention Specialist while they are implementing their EBP's.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

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

a) ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Bureau of Behavioral Health/Addictive Services, Division of Wellness and Recovery Supports has a State Epidemiological Outcomes Workgroup (SEOW) that was founded in October 2006. It consists of representatives from sister state agencies including the Depts. of Health, Education, Medicaid and Transportation and Public Safety. Additionally, The Tobacco Quit Line, Community Level Service Providers, Elected Officials, The MS Attorney Generals' Office, State Team Evaluators and many concerns citizens serve on this workgroup. This Evidence Based Work Group is spearheaded by The State Epidemiologist and the NPN. One of the many tasks that the SEOW is responsible for is developing and maintaining special task work groups and committees that assist in the data driven decision making process that steers all prevention activities in Mississippi. Producing an annual State Epidemiological Profile is another key function of the SEOW, as well as, providing all aspect of data collection, analyzing and maintenance for State Level prevention services. This provides for data decision making in the allocation of resources and areas of focus. Finally, Technical Assistance, Training and Education for the Community Level Service Providers/Sub Grantees are functions carry out by the SEOW that are paramount to the success of the State's Prevention Workforce.

Narratve Question

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

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

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

b) Education:

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

c) Alternatives:

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

d) Problem Identification and Referral:

Activities include a student assistance and employee assistance programs and peer counseling. BBH/AS's Alcohol and Drug Treatment and Prevention Resource directories are utilized to make referrals whenever the need arises. Some of the programs described under the Education strategy could also fall under this category.

e) Community-Based Processes:

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

f) Environmental:

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

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

If yes, please describe

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

TA Request:

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

Narratve Question

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

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

Evaluation

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

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Mississippi does not have a formal state evaluation plan for substance use disorder prevention that was developed within the last five years. However, MS does have a guidance document in place that we are able to reference when the need(s) arise to assist in ensuring a valid evaluation process.

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

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

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

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

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

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

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

Footnotes:

BUREAU OF BEHAVIORAL HEALTH/ADDICTIVE SERVICES
FY 2020 –2022
STATE PLAN

Prevention Works.
Treatment is Effective.
People Recover.

Bureau of Behavioral Health/Addictive Services

STATE PLAN

FY 2020-2022

Presented by:

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(601) 899-8880
sparker@mbp.ms.gov

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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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/or 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 BehavioralHealth/Addictive Services

Mission Statement

The mission of the Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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. The Bureau oversees the accounting/payroll, auditing, and grants management functions of the agency. ***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 Behavioral Health/Addictive Services is responsible for planning, development and supervision of an array of services and supports for children/youth and adults in the state with serious emotional disturbance, serious mental illness and substance use disorders. The Bureau is comprised of three areas including State-Operated Programs, Community Mental Health Services, and Addictive Services. The Bureau is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services 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 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 all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects.

The Bureau of Certification and Quality Outcomes is responsible for ensuring the safe provision of high quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes three divisions: Certification, Incident Management, and Professional Licensure and Certification (PLACE).

The Bureau of Human Resources is responsible for the employment and workforce development. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. 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** Rita Berthay, 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 Street P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 6: Attala, Bolivar, Carroll, Grenada, Holmes, Humphreys, Issaquena, Leflore, Montgomery, Sharkey, Sunflower, Washington	**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 1011 Main Street Columbus, MS 39701 (662) 327-7916
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 7777 Jackson, MS 39209 (601) 321-2400
Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	**Weems Community Mental Health Center** Russ Andreacchio, 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** Mona Gauthier, 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** Vickie Taylor, 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

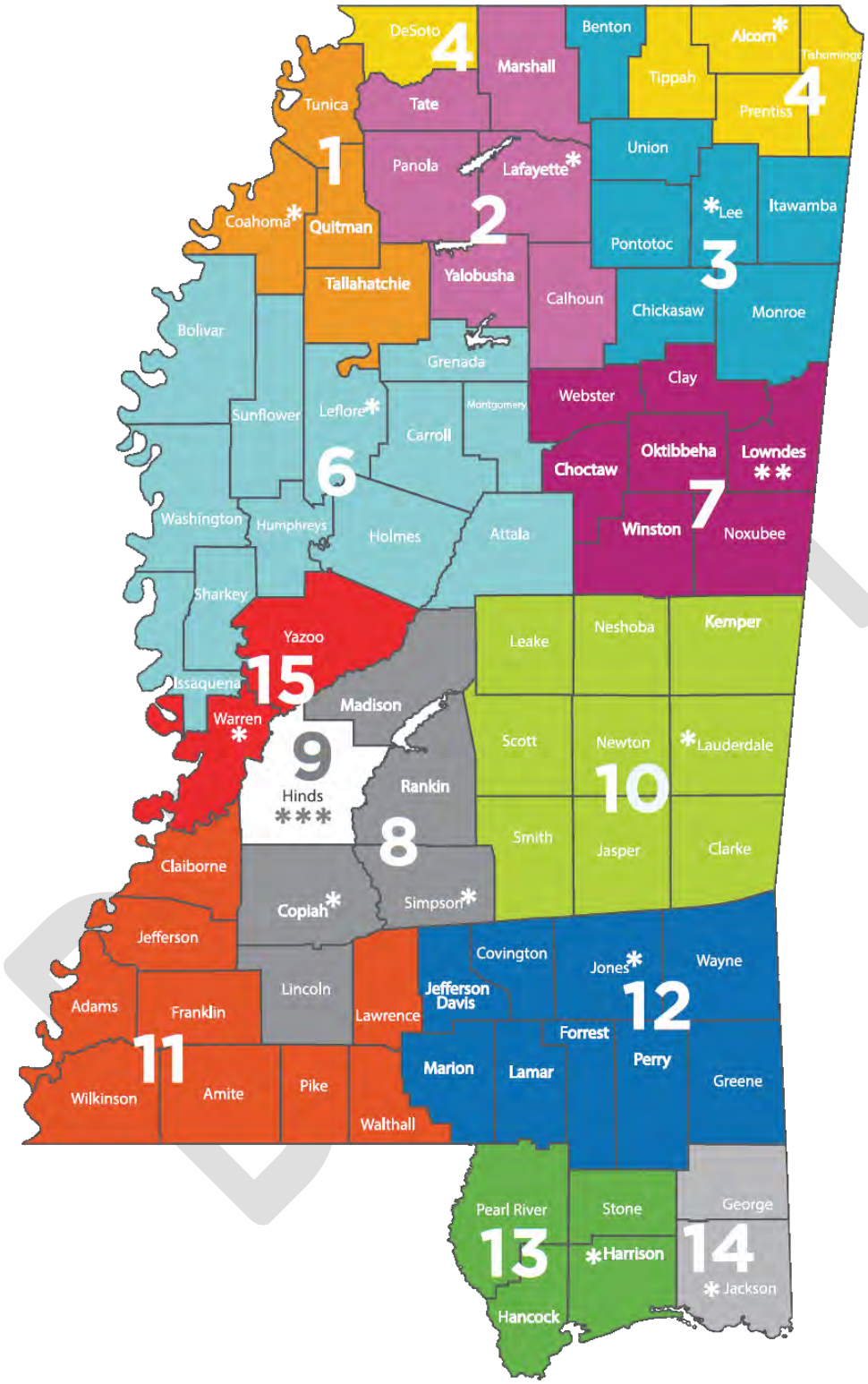
SUBSTANCE USE DISORDER SERVICES

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** **Clint Crawford, Director, Alcohol & Drug Services** **2434 Eason Blvd.** **Tupelo, MS 38801** **(662) 844-1717**
Region IV: **Alcorn, DeSoto, Prentiss, Tippah, and Tishomingo** **http://www.regionivmhs.com**	**Region IV Mental Health Services** **Adrian Owens, 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** **Jonathan Grantham, 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** **Keenyn Wald, 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** **Ann Rodio, 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** **Deidra O'Connor, 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** **Matt Quin, Director, Alcohol & Drug Services** **1701 White Street, Box 768** **McComb, MS 39649** **(601) 684-2173**
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** **Dean Doty, 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** **Amy Turner, 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** **Warner Buxton, Director, Alcohol & Drug Services** **3444 Wisconsin Ave.** **Vicksburg, MS 39180** **(601) 634-0181**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Regional Community-Based Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Tutwiler	Fairland Center	Region I: Community Mental Health Center	52 24- Male 28-Female
Hazlehurst	Female Residential	Region VIII: Mental Health Services Treatment Center	11 11-Female
Mendenhall	Male Residential	Region VIII: Mental Health Services Treatment Center	21 21- Male
Meridian	Weems Life Care	Region X: Weems Community Mental Health Center	35 16- Male 16-Female 1-Handicap 2-Overflow
Moselle	Clearview Recovery	Region XII: Pine Belt Healthcare Resources	54 40-Male 14-Female
Gulfport	Crossroads Recovery Center	Region XIII: Gulf Coast Mental Health	42 24 Male 14-Female
			Total Bed Capacity: 215

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

Location	Program	Agency	Bed Capacity
Oxford	Haven House	Region II: Communicare	32 22-Male

			10-Female
Tupelo	Region III: CDC	Region III: Lifecore	41 As needed
Corinth	Region IV: CDC	Region IV: Timber Hills Mental Health Services	24 16- Male 8-Female
Greenwood	Denton House CDC	Region VI: Life Help	44 32- Male 12-Female
Columbus	Cady Hill, The Pines & Recovery House	Region VII: Community Counseling Services	28 18- Male 10-Female 6-Female
Hazlehurst	Female Residential	Region VIII: Mental Health Services Treatment Center	11 11-Female
Pascagoula	Stevens Center	Region XIV: Singing River Services	18 6- Male 12-Female
Vicksburg	Warren-Yazoo CDC	Region XV: Warren Yazoo Mental Health	21 15- Male 6-Female
			Total Bed Capacity: 178

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	68 42-Male 26-Female
Jackson	The Friendship Connection	Center for Independent Learning	12 12-Female
			Total Bed Capacity: 88

Community-Based Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Oxford	Haven House	Region II: Communicare	16 14-Male 2-Female
Tupelo	Region III CDC	Region III: Life Core	5 As Needed
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 & Recovery House	Region VII: Community Counseling Services	16 10-Male 6-Female 6-Female
Pascagoula	Stevens Center	Region XIV: Singing River Services	4 2-Male

			2-Female
Vicksburg	Warren Yazoo CD	Region XV: Warren Yazoo Mental Health	4 4-Male 0-Female
			Total Bed Capacity: 88

Free-Standing Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Jackson	New Beginnings	Catholic Charities	8 8-Female
Jackson	Friendship Connection	Center for Independent Learning	12 12-Female
			Total Bed Capacity: 20

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

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 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 Behavioral Health/Addictive 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 social mediaoften promote or convey acceptance of drug use behaviors. 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 several ways. The Bureau of Behavioral Health/Addictive 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://oregonpgs.org/wp-content/uploads/2016/07/6csap-strategies).

Through the Bureau of Behavioral Health/Addictive Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Behavioral Health/Addictive 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 Strategic Prevention Framework-State Incentive Grant (SPF-SIG), awarded to the Bureau of Behavioral Health/Addictive Services in 2001, allowed the Bureau of Behavioral Health/Addictive Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 youths 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).

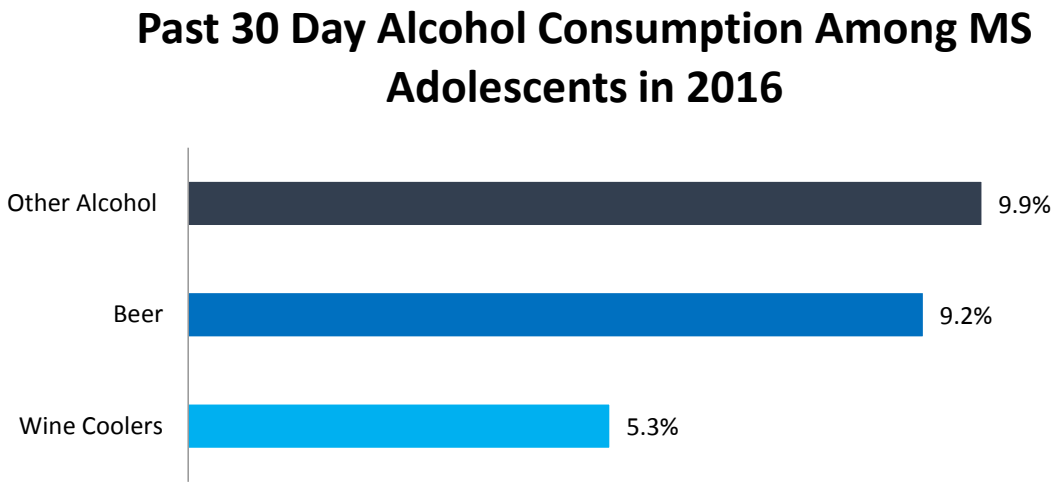

Figure 1: An illustration of past 30 day alcohol consumption among students that participated in the 2016 SmartTrack Survey, grouped by types of alcoholic beverages consumed.

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).

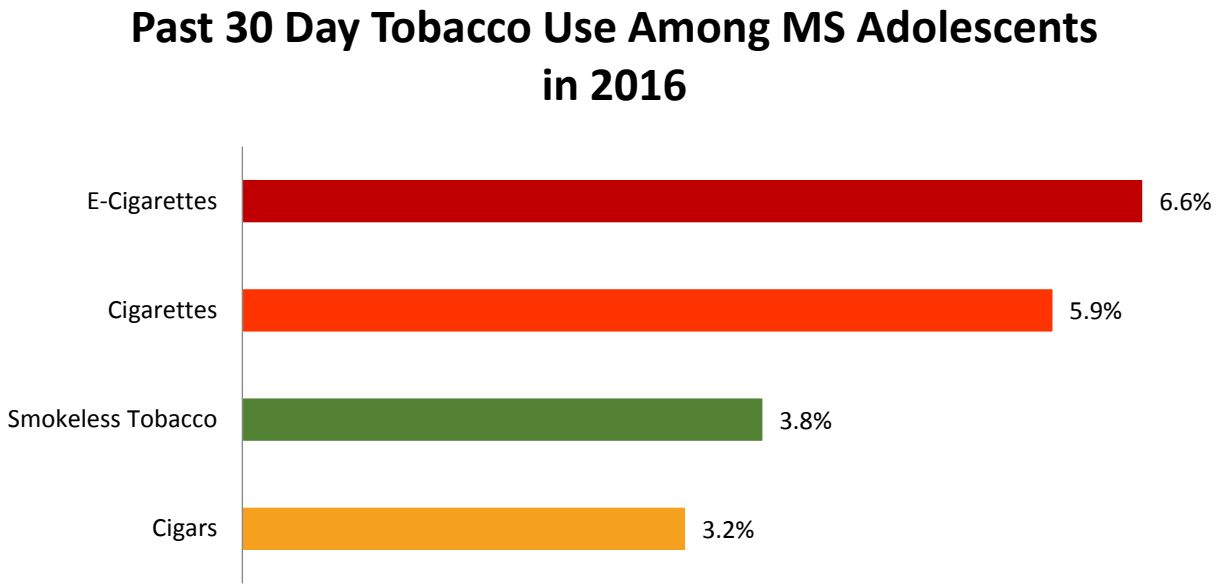

Figure 2: An illustration of past 30 day tobacco use among students that participated in the 2016 SmartTrack Survey, grouped
by different tobacco products consumed.

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).

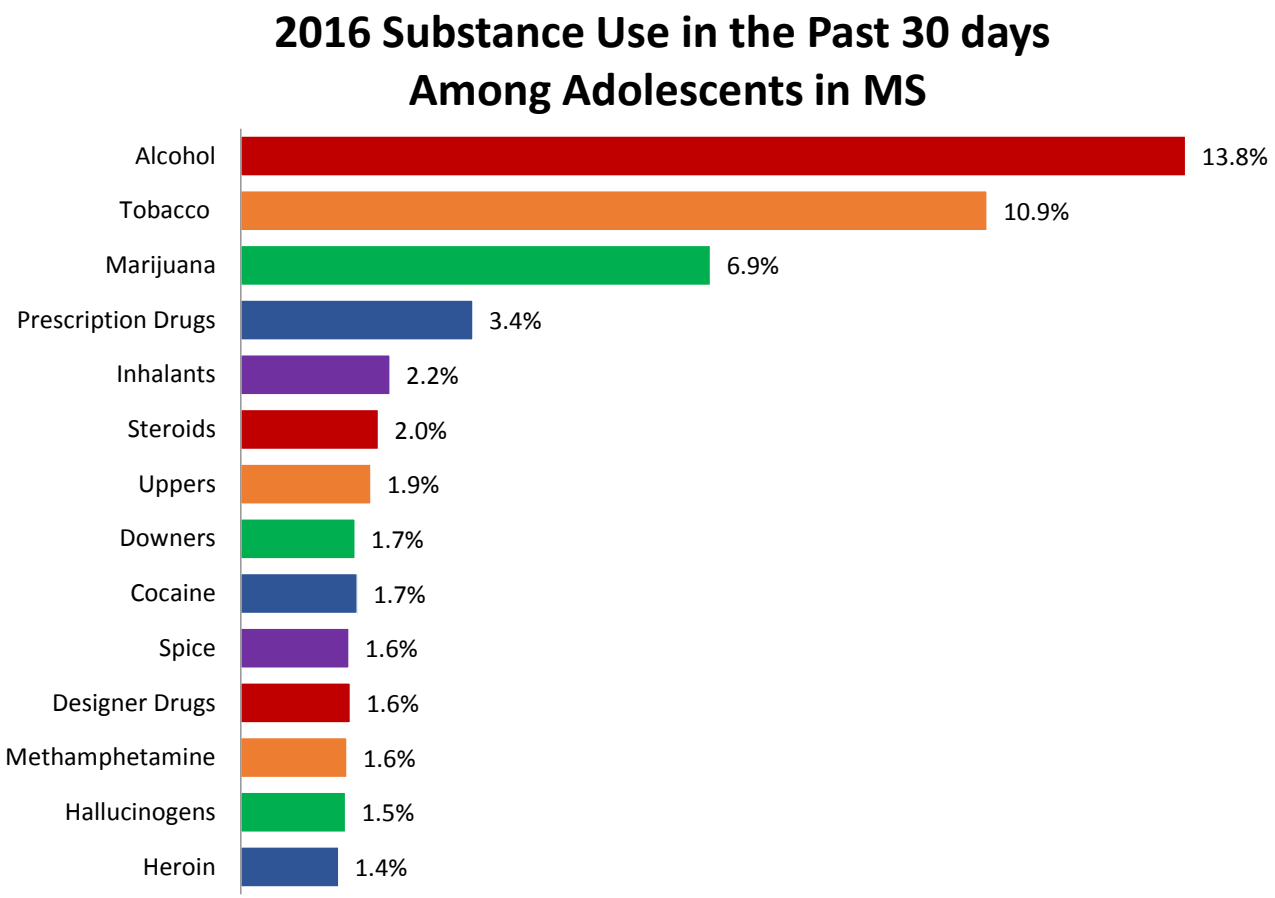

Figure 3: A display of drug use reported in the past 30 days by Mississippi students that participated in the 2016 SmartTrack Survey.

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

Persons living with HIV/AIDS in Mississippi in 2016 totaled 9,458. The majority (72.9%) of the cases were Africana American, 19.1% Caucasians and then 3.2% Hispanic/Latina. In 2014, there were 6,539 (72.1% individuals of African American decent 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). The MS State Department of Health, Bureau of STD/HIV reported that in 2016 there were 424 newly diagnosed cases of HIV disease. (WLBT, 2019). The City of Jackson (Hinds County) has the fourth highest rate of HIV infection in the nation, with 1,036 people. Jackson is just 1 of 5 southern metropolitan areas with the highest rate of HIV infection, high teen HIV infection rates, and high HIV death rates for young women and adults. Out of the 82 counties in MS, the top five counties in 2016 which had the most people living with HIV were Hinds (1,036), Coahoma (904), Tunica (819), Sunflower (881), and Forrest (629). (AIDVu.org, 2016).

Figure A: A display of Mississippians living with HIV, in 2016. Counties are color coded by rate of existing cases of HIV per 100,000. see map attached. (AIDSVu.org., 2016)
https://aidsvu.org/state/mississippi/

Rate of Mississippians Living with HIV in 2016

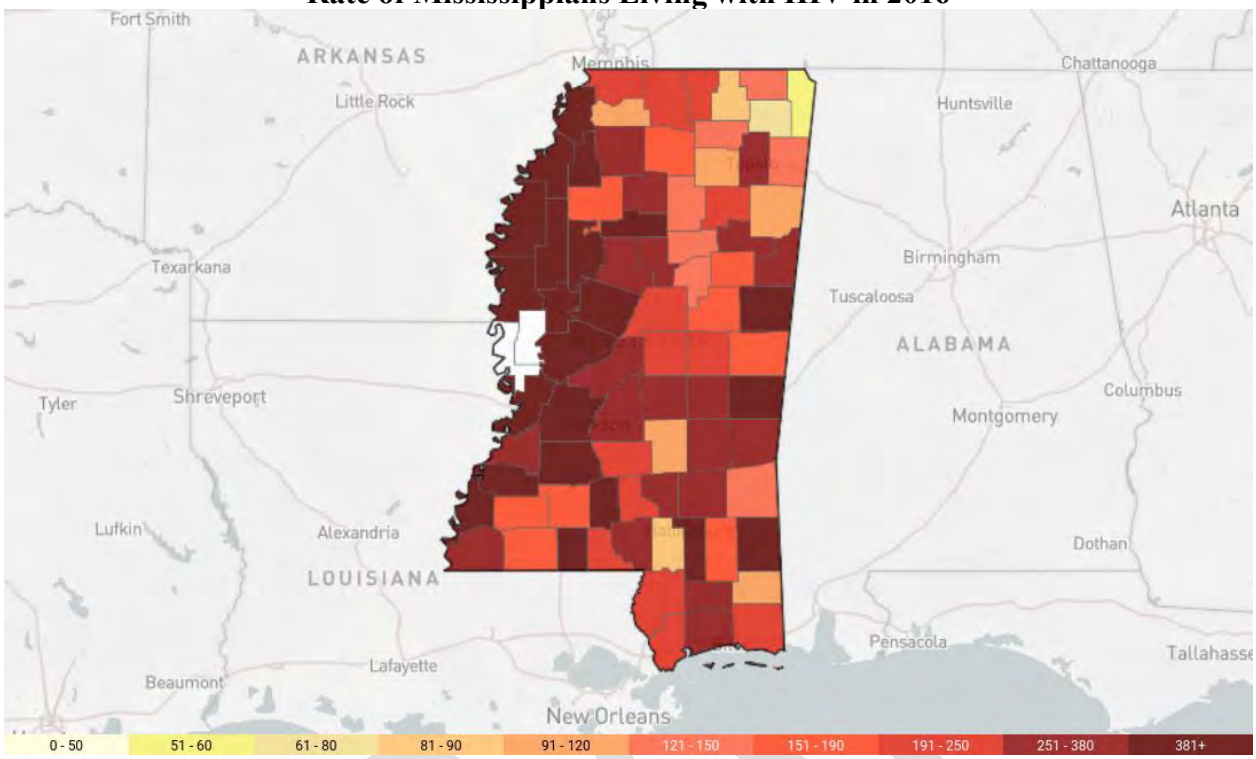

Figure 4: A display of Mississippians living with HIV, by county, in 2016. Counties are color coded by rate of existing cases of HIV per 100,000 (AIDSVu.org, 2016).

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

The DMH, Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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) peer 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 vital 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 Behavioral Health/Addictive Services supports specialized services for the following populations:

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

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

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

Access to Community-Based Transitional Residential Services

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

Intended to be an intermediate stage between primary treatment and independent re-entry into the community, the treatment focuses on the enhancement of coping skills needed to lead a productive and fulfilling life, free of chemical dependency. A primary objective of this type of treatment is to encourage and aid in the pursuit and acquisition of vocational, employment, and/or related activities. Although all substance use disorder treatment programs are accessible to pregnant women, there are two specifically 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 Behavioral Health/Addictive 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 and Peer Recovery Support Services. Recovery Support Services and Peer Recovery Support Services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. These services 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 and Peer Recovery Support Services may be provided in conjunction with treatment and/or separate and distinct services to individuals and families who desire and need them. Recovery Support Services and Peer Recovery Support Services may be delivered by peers, professionals, faith-based and community-based groups, and others designated 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. Since many of these services are delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge.

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 Bureau of Behavioral Health/Addictive 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, 12 juvenile programs, and 3 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.

Currently, the Bureau of Behavioral Health/Addictive 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 BBH/AS, 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 community providers 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-BBH/AS 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive Services (BBH/AS) 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 began by January 1, 2018.
1st year target/outcome measurement:	Increase by 3% the number of pregnant women who successfully complete treatment during 2019-2020.
2nd year target/outcome measurement:	Increase by 3% the number of pregnant women who successfully complete treatment during 2020-2021.
Data Source:	Annual Monitoring visits, Central Data Repository, and Programs will provide policy and procedures ensuring priority is given to pregnant women. Data from the Addictive Services Point of Service Spreadsheet.
Description of Data:	BBH/AS 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 began by January 1, 2018.
1st year target/outcome measurement:	Increase by 30% the number of pregnant women that have access to MAT during FY 2019-2020.
2nd year target/outcome measurement:	Increase by 35% the number of pregnant women that have access to MAT during FY 2020-2021.
Data Source:	Annual monitoring visits.
Description of Data:	BBH/AS 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	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 and State Opioid Response grant to increase the number of certified MAT facilities and

outcome measures:	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 began by January 1, 2018.

1st year target/outcome measurement:	Increase by 5% the number of IV Drug Users who successfully complete treatment after admission.
2nd year target/outcome measurement:	Increase by 10% 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:	BBH/AS 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:

Increase access to individuals determined to be at high risk for HIV to HIV Rapid Testing & Education services.

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.

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 Behavioral Health/Addictive Services staff through routine monitoring visits.

Indicator #1:	Increase access to individuals determined to be at high risk for HIV to HIV Rapid Testing & Education services.
Baseline Measurement:	Implementation will begin by January 1, 2019.
1st year target/outcome measurement:	Increase by 1% the number of at risk individuals that will receive rapid testing for HIV and Hepatitis during 2019-2020
2nd year target/outcome measurement:	Increase by 2% the number of at risk individuals that will receive rapid testing for HIV and Hepatitis during 2020-2021
Data Source:	Monitoring visits and Annual SABG progress report
Description of Data:	In accordance to the Grant Agreement established amongst the DMH and the Mississippi Department of Health (MSDH), the MSDH will oversee data collection regarding HIVservices. MSDH will collect and report HIV data to the DMH annually or upon request. BBH/AS will continue to 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 (Peer Support) Services

Goal:

Increase workforce awareness and understanding of the DMH Operational Standards on Recovery Peer 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 Peer Support Services, BBH/AS will continue to provide technical assistance, programmatic development training, and state-wide provider training to all service providers on what Recovery Peer Support Services is and what it should look like for their community.

Indicator #1:	Increase the number of peer support specialists by 3%.
Baseline Measurement:	Currently there are 60 certified peer support specialists in the state for SUD.

1st year target/outcome measurement:	Increase the number of peer support specialists by 3%.
2nd year target/outcome measurement:	Increase the number of peer specialists by 3%.
Data Source:	Workforce development training database.
Description of Data:	The workforce development division of DMH certifies peer 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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 began by January 1, 2018.
1st year target/outcome measurement:	At least 25 individuals utilize the functional assessment.
2nd year target/outcome measurement:	At least 30 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 Behavioral Health/Addictive Services (BBH/AS) have developed the Co-Occurring Capabilities of Mississippi project. The BBH/AS 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 BBH/AS conducted 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 BBH/AS 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 2018-2019, 50% of the CMHCs Co-Occurring Conditions was identified.
1st year target/outcome measurement:	Increase the number of CMHCs to be assessed (DDCMHT) to 60% by the end of grant year 2019.
2nd year target/outcome measurement:	Increase by an additional 70% by the end of grant year 2020.
Data Source:	DDCMHT Scoring Results
Description of Data:	DDCMHT Scoring Results
Data Issues/caveats that affect the outcome measures:	Obtaining the by-in from the CMHCs during the assessment process. Willingness of the provider to embrace the changes needed as a result of the DDCMHT assessment.

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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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:

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

BBH/AS 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.

BBH/AS 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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:

BBH/AS 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:

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

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

BBH/AS 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 Behavioral Health/Addictive ServicesBureau of Behavioral Health/Addictive 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:

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

BBH/AS 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.

BBH/AS 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 BEHAVIORAL HEALTH/ADDICTIVE SERVICES

PROJECTED EXPENDITURES FOR FY 2020

ACTUAL EXPENDITURES FOR FY 2018-2020

FEDERAL/ STATE	FUNDING SOURCE	PROJECTED FY 2020	ACTUAL FY 2019	ACTUAL FY 2018
Federal	Substance Abuse Block Grant	$13,805,681	$12,704,928	$12,292,757
				$133,575
	MS Prevention Alliance Communities and Colleges Grant	$300,000	$1,304,202	$1,908,467
	MS State Targeted Response to the Opioid Crisis Grant	$500,000	$3,428,665	$3,415,040
	State Opioid Response Grant	$11,500,000	$2,447,345	N/A
	Second Chance Program for Adults w/ Co-occurring Substance Abuse & Mental Health	$60,000	$175,229	$127,367
Total Federal		**$26165,681**	**$20,060,369**	**$17,877,206**
State of MS				

	3% Alcohol Tax	$7,000,000	$7,036,659	$6,140,698
	State General Funds	N/A	N/A	$N/A
Total State		**$7,000,000**	**$7,036,659**	**$6,140,698**
Grand Total		**$33,165,681**	**$27,097,028**	**$24,017,904**

Summary

It is the goal of the Mississippi Department of Mental Health-Bureau of Behavioral Health/Addictive 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.

BUREAU OF BEHAVIORAL HEALTH/ADDICTIVE SERVICES

FY 2020 –2022

STATE PLAN

Prevention Works.
Treatment is Effective.
People Recover.

Department of Mental Health

Bureau of Behavioral Health/Addictive Services

STATE PLAN

FY 2020-2022

Presented by:

Felita Bell, MSL,
Program Administrator

Jake Hutchins, MSW
Bureau Director

Pamela Smith, M.Ed.,
Division Director
Substance Use Disorders Treatment Services

Chuck Oliphant, M.Ed., CMHT, CADC
Division Director
Wellness and Recovery

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

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/or 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 Behavioral Health/Addictive Services

Mission Statement

The mission of the Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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. The Bureau oversees the accounting/payroll, auditing, and grants management functions of the agency. ***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 Behavioral Health/Addictive Services is responsible for planning, development and supervision of an array of services and supports for children/youth and adults in the state with serious emotional disturbance, serious mental illness and substance use disorders. The Bureau is comprised of three areas including State-Operated Programs, Community Mental Health Services, and Addictive Services. The Bureau is responsible for the administration of state and federal funds utilized to develop, implement and expand a comprehensive continuum of services 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 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 all outreach efforts including internal and external communications, public awareness campaigns, trainings, statewide suicide prevention, and special projects.

The Bureau of Certification and Quality Outcomes is responsible for ensuring the safe provision of high quality services from qualified individuals in programs certified by the Mississippi Department of Mental Health. The Bureau includes three divisions: Certification, Incident Management, and Professional Licensure and Certification (PLACE).

The Bureau of Human Resources is responsible for the employment and workforce development. Such matters include all aspects of human core capital processing, recruitment, retention, benefits, worker's compensation, job performance monitoring, and discipline. 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 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 programs 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** Rita Berthay, 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 Street P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883

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Region 6: Attala, Bolivar, Carroll, Grenada, Holmes, Humphreys, Issaquena, Leflore, Montgomery, Sharkey, Sunflower, Washington	**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 1011 Main Street Columbus, MS 39701 (662) 327-7916
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 7777 Jackson, MS 39209 (601) 321-2400

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Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	**Weems Community Mental Health Center** Russ Andreacchio, 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** Mona Gauthier, 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** Vickie Taylor, 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
Community Living Programs
Supported Employment Services
HCBS Attendant Care

HCBS Behavioral Support/Intervention
HCBS Community Respite
HCBS In-home Nursing Respite
HCBS ICF/MR Respite
HCBS Day Habilitation
HCBS Support Coordination
HCBS Occupational, Physical, and Speech/Languages Therapies

Services for Individuals with Substance Use Disorders

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

SUBSTANCE USE DISORDER SERVICES

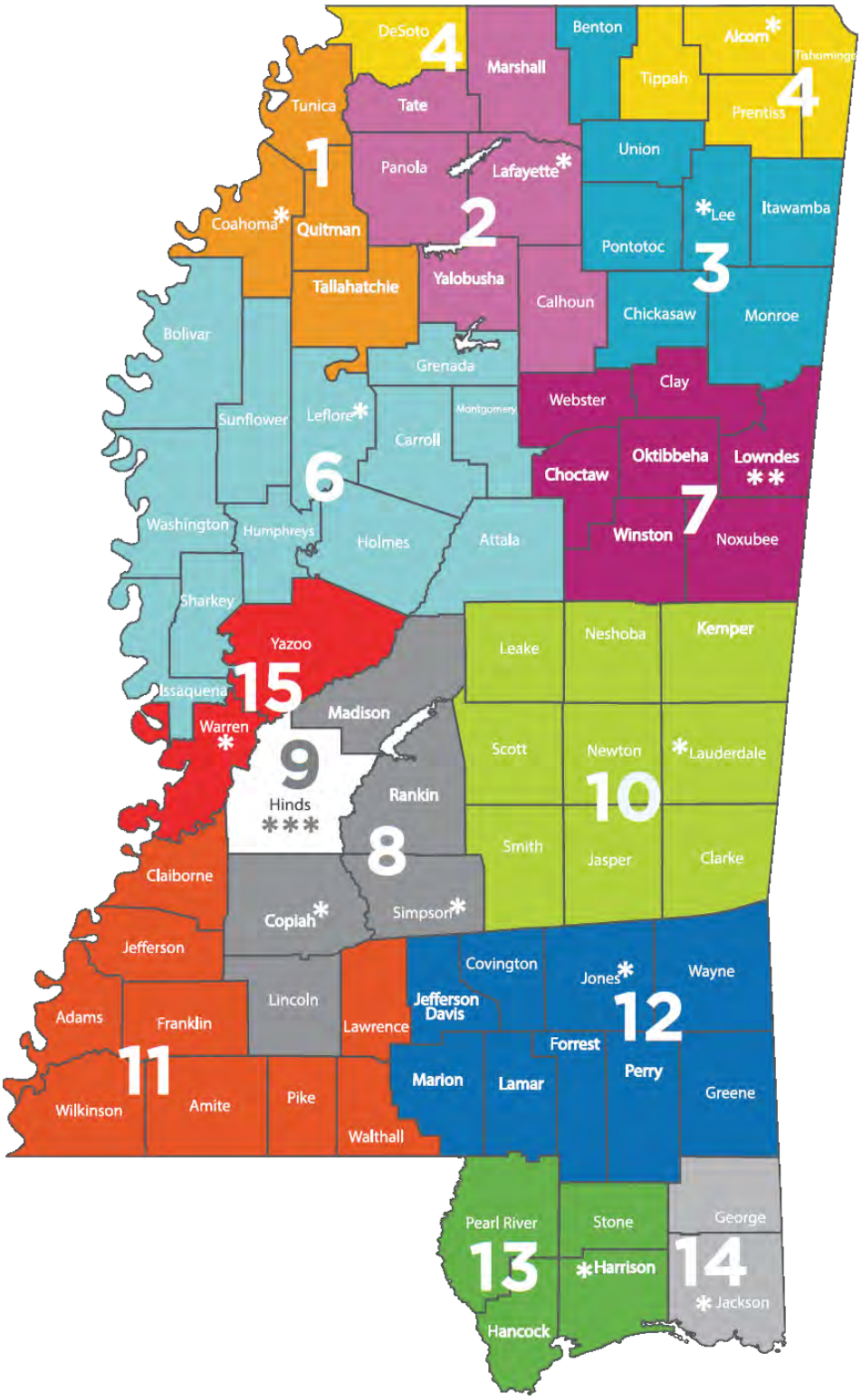
Contact Information

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**
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** **Clint Crawford, Director, Alcohol & Drug Services** **2434 Eason Blvd.**
Region IV: **Alcorn, DeSoto, Prentiss, Tippah, and Tishomingo** **http://www.regionivmhs.com**	**Region IV Mental Health Services** **Adrian Owens, Director, Alcohol & Drug Services** **303 North Madison Street** **P.O. Box 839**

Region VI: **Attala, Bolivar, Carroll, Grenada, Holmes, Humphreys, Issaquena, Leflore, Montgomery, Sharkey, Sunflower, and Washington** **http://www.region6-lifehelp.org**	**Life Help** **Jonathan Grantham, 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** **Keenyn Wald, Director, Alcohol & Drug Services** **1001 Main Street** **Columbus, MS 39701**
Region VIII: **Copiah, Lincoln, Madison, Rankin, and Simpson** **http://www.region8mhs.org**	**Region VIII Mental Health Services** **Ann Rodio, Director, Alcohol & Drug Services** **613 Marquette Road, Box 88**
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** **Deidra O'Connor, 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** **Matt Quin, Director, Alcohol & Drug Services** **1701 White Street, Box 768** **McComb, MS 39649** **(601) 684-2173**
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** **Dean Doty, 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** **Amy Turner, 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** **Warner Buxton, Director, Alcohol & Drug Services** **3444 Wisconsin Ave.** **Vicksburg, MS 39180** **(601) 634-0181**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Marshall
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Lee*
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Grenada
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Webster
Sunflower
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Covington
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Marion
Lamar
Greene
Wilkinson
Amite
Pike
Walthall
Pearl River
Stone
George
13
Harrison*
14
Jackson*
Hancock

Regional Community-Based Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Tutwiler	Fairland Center	Region I: Community Mental Health Center	52 24- Male 28-Female
Hazlehurst	Female Residential	Region VIII: Mental Health Services Treatment Center	11 11-Female
Mendenhall	Male Residential	Region VIII: Mental Health Services Treatment Center	21 21- Male
Meridian	Weems Life Care	Region X: Weems Community Mental Health Center	35 16- Male 16-Female 1-Handicap 2-Overflow
Moselle	Clearview Recovery	Region XII: Pine Belt Healthcare Resources	54 40-Male 14-Female
Gulfport	Crossroads Recovery Center	Region XIII: Gulf Coast Mental Health	38 24 Male 14-Female
			Total Bed Capacity: 211

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

Location	Program	Agency	Bed Capacity
Oxford	Haven House	Region II: Communicare	32 22-Male 10-Female
Tupelo	Region III: CDC	Region III: Lifecore	41 As needed
Corinth	Region IV: CDC	Region IV: Timber Hills Mental Health Services	24 16- Male 8-Female
Greenwood	Denton House CDC	Region VI: Life Help	44 32- Male 12-Female
Columbus	Cady Hill, The Pines & Recovery House	Region VII: Community Counseling Services	34 18- Male 10-Female 6-Female
Hazlehurst	Female Residential	Region VIII: Mental Health Services Treatment Center	11 11-Female
Pascagoula	Stevens Center	Region XIV: Singing River Services	18 6- Male 12-Female
Vicksburg	Warren-Yazoo CDC	Region XV: Warren Yazoo Mental Health	21 15- Male 6-Female
			Total Bed Capacity: 225

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	68 42-Male 26-Female
Jackson	The Friendship Connection	Center for Independent Learning	12 12-Female
			Total Bed Capacity: 88

Community-Based Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Oxford	Haven House	Region II: Communicare	22 14-Male 2-Female
Tupelo	Region III CDC	Region III: Life Core	5 As Needed
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 & Recovery House	Region VII: Community Counseling Services	16

			10-Male 6-Female 6-Female
Pascagoula	Stevens Center	Region XIV: Singing River Services	4 2-Male 2-Female
Vicksburg	Warren Yazoo CD	Region XV: Warren Yazoo Mental Health	4 4-Male 0-Female
			Total Bed Capacity: 99

Free-Standing Transitional Residential Substance Use Disorder – Adult Programs

Location	Program	Agency	Bed Capacity
Jackson	New Beginnings	Catholic Charities	8 8-Female
Jackson	Friendship Connection	Center for Independent Learning	12 12-Female
			Total Bed Capacity: 20

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

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 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 Behavioral Health/Addictive 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 social media often promote or convey acceptance of drug use behaviors. These factors must be addressed in prevention programming. Equally important is the willingness of prevention professionals to remain aware of new research and be prepared to expand or modify their programs, as needed, to address any new causes.

A variety of strategies must be employed to successfully reduce problems associated with substance use. Prevention strategies have been categorized in several ways. The Bureau of Behavioral Health/Addictive 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://oregonpgs.org/wp-content/uploads/2016/07/6csap-strategies).

Through the Bureau of Behavioral Health/Addictive Services, Mississippi has made great strides in improving the prevention delivery service system during the past five years. The Bureau of Behavioral Health/Addictive 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 Strategic Prevention Framework-State Incentive Grant (SPF-SIG), awarded to the Bureau of Behavioral Health/Addictive Services in 2001, allowed the Bureau of Behavioral Health/Addictive Services to fund additional programs utilizing evidence-based programs and more than doubling the number of individuals and families served. In October 2006, the Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 youths 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 compared 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).

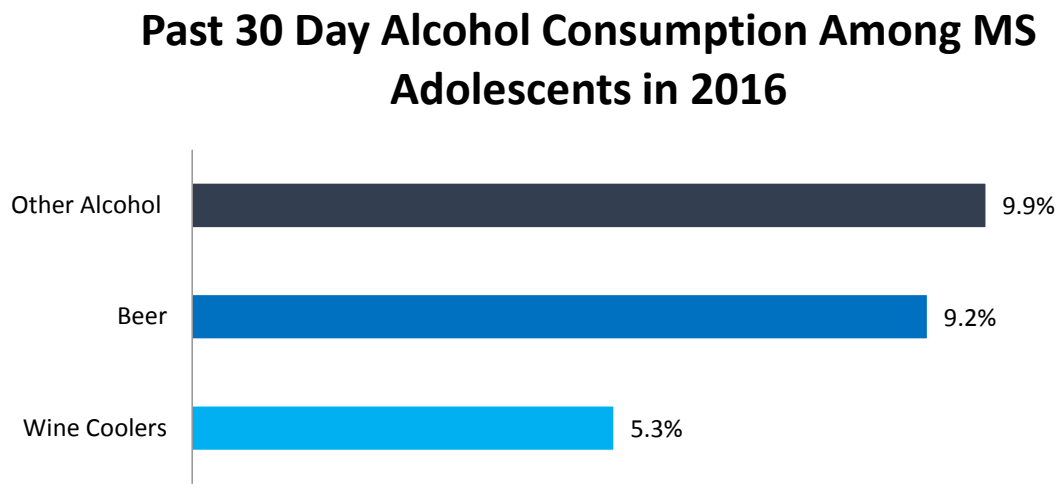

Figure 1: An illustration of past 30 day alcohol consumption among students that participated in the 2016 SmartTrack Survey, grouped by types of alcoholic beverages consumed.

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).

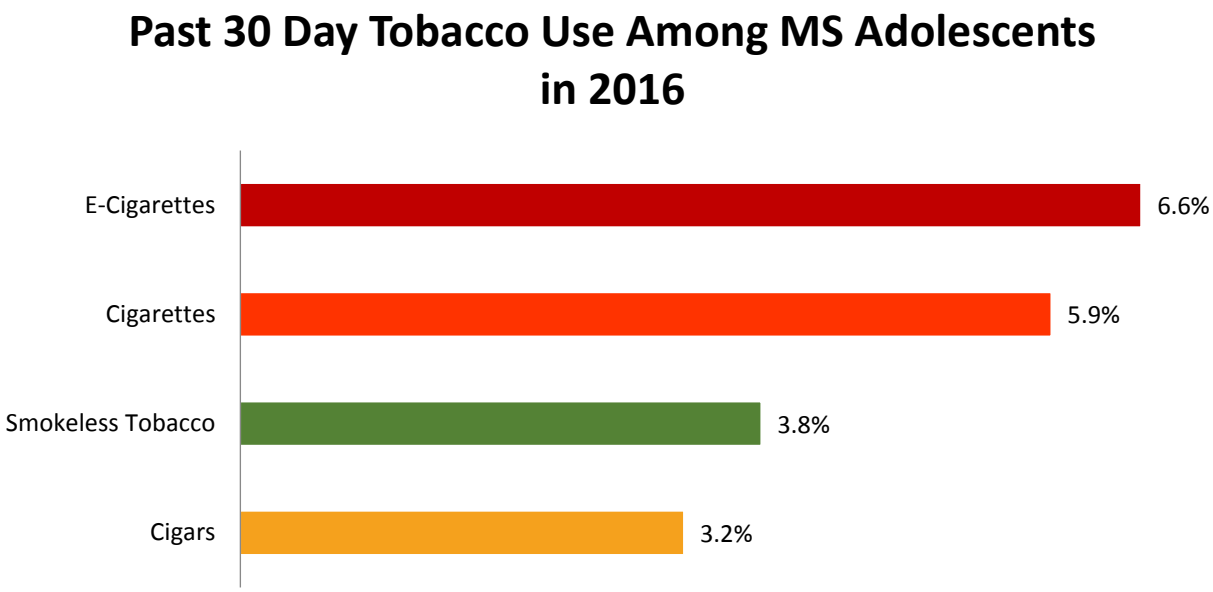

Figure 2: An illustration of past 30 day tobacco use among students that participated in the 2016 SmartTrack Survey, grouped

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).

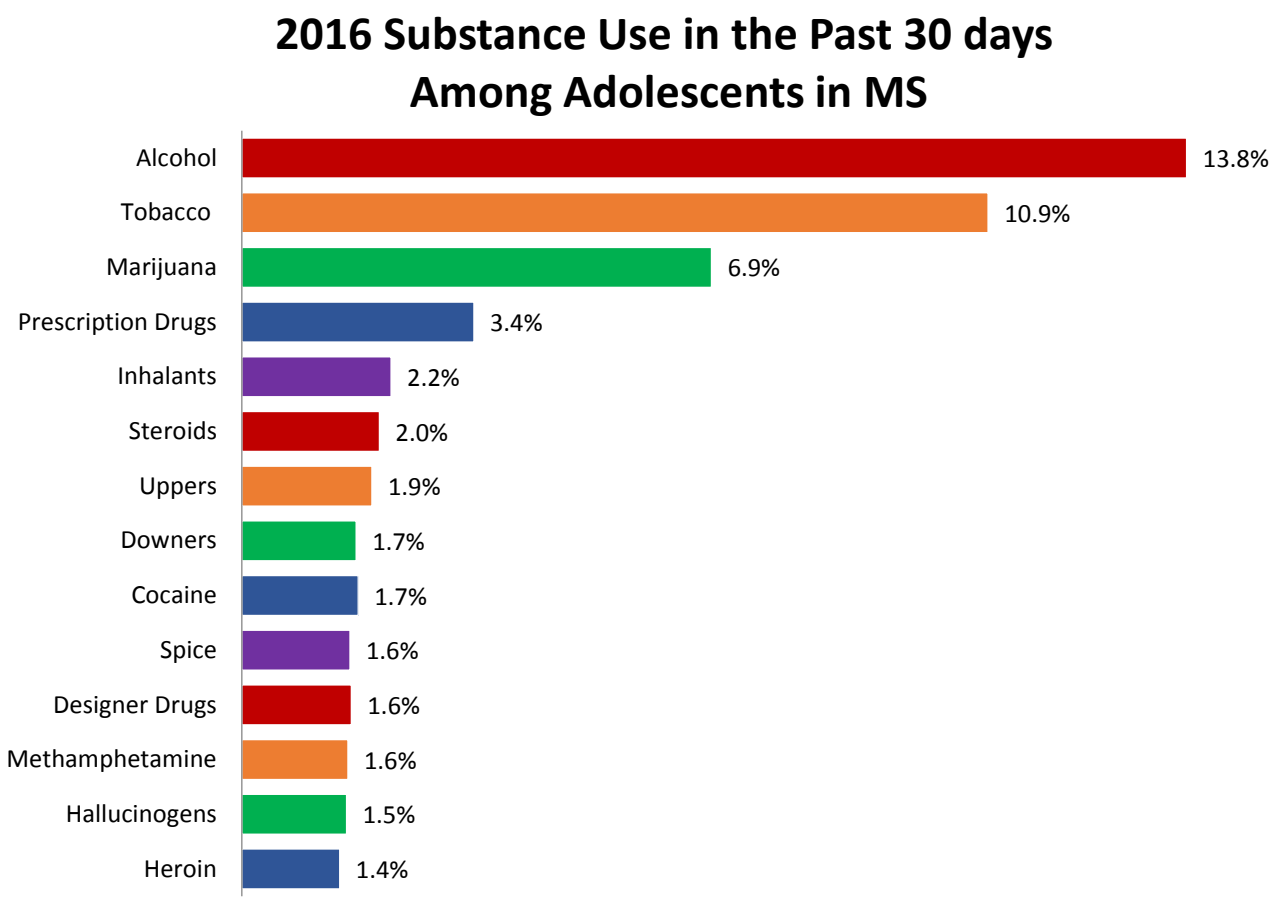

Figure 3: A display of drug use reported in the past 30 days by Mississippi students that participated in the 2016 SmartTrack Survey.

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 breaks down 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	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

Persons living with HIV/AIDS in Mississippi in 2016 totaled 9,458. The majority (72.9%) of the cases were Africana American, 19.1% Caucasians and then 3.2% Hispanic/Latina. In 2014, there were 6,539 (72.1% individuals of African American decent living in Mississippi with HIV (MSDH, 2015). This is particularly important to note since African Americans represent only 37.5% of Mississippi's general population (Census, 2016). The MS State Department of Health, Bureau of

STD/HIV reported that in 2016 there were 424 newly diagnosed cases of HIV disease. (WLBT, 2019). The City of Jackson (Hinds County) has the fourth highest rate of HIV infection in the nation, with 1,036 people. Jackson is just 1 of 5 southern metropolitan areas with the highest rate of HIV infection, high teen HIV infection rates, and high HIV death rates for young women and adults. Out of the 82 counties in MS, the top five counties in 2016 which had the most people living with HIV were Hinds (1,036), Coahoma (904), Tunica (819), Sunflower (881), and Forrest (629). (AIDVu.org, 2016).

Figure A: A display of Mississippians living with HIV, in 2016. Counties are color coded by rate of existing cases of HIV per 100,000. see map attached. (AIDSVu.org., 2016). https://aidsvu.org/state/mississippi/

Rate of Mississippians Living with HIV in 2016

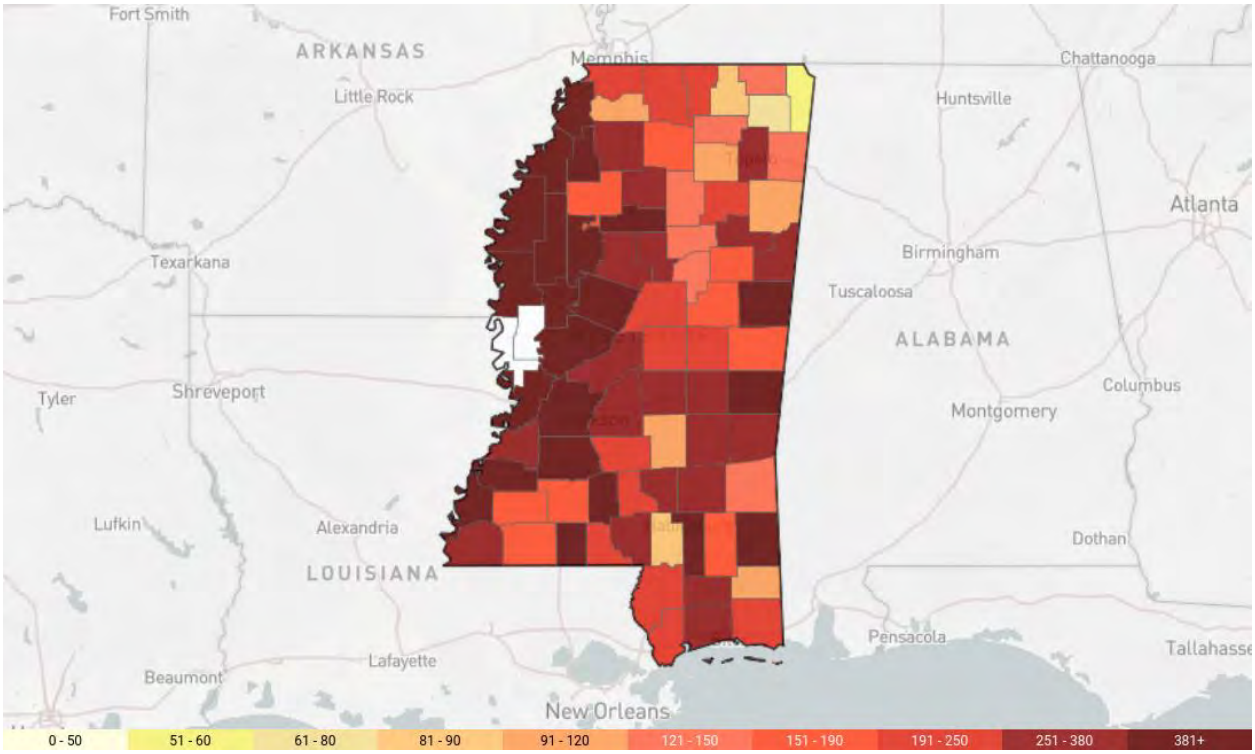

Figure 4: A display of Mississippians living with HIV, by county, in 2016. Counties are color coded by rate of existing cases of HIV per 100,000 (AIDSVu.org, 2016).

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

The DMH, Bureau of Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 disorder 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 disorder 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 Behavioral Health/Addictive Services is responsible for administering 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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) peer 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 vital role to play in the treatment of the individual. They can assist by both participating in the development of the treatment plan and family therapy. Where family support is active, the user relies on the strengths of every family member as a source of healing. Several ways the providers encourage and help elicit family support is through the distribution of printed materials, education, internet access, and knowledge of the referral and placement process.

Access to Community-Based Primary Residential Services

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

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

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

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

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

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

Access to Community-Based Transitional Residential Services

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

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

Access to Community-Based Outpatient Services

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

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

General Outpatient Services for Opiate Addiction: The Bureau of Behavioral Health/Addictive 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 and Peer Recovery Support Services. Recovery Support Services and Peer Recovery Support Services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. These services 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 and Peer Recovery Support Services may be provided in conjunction with treatment and/or separate and distinct services to individuals and families who desire and need them. Recovery Support Services and Peer Recovery Support Services may be delivered by peers, professionals, faith-based and community-based groups, and others designated 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. Since many of these services are delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge.

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 Bureau of Behavioral Health/Addictive 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, 12 juvenile programs, and 3 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.

Currently, the Bureau of Behavioral Health/Addictive 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 BBH/AS, 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 Behavioral Health/Addictive 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 community providers that offer evidence-based, FDA approved MAT.

Strategies to attain the objectives:

1. Implement and expand access to and utilize 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-BBH/AS 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 Behavioral Health/Addictive Services (BBH/AS) will continue to certify and provide funding to support fourteen (14) community-based primary residential treatment programs for adult females and males. While all of the

programs serve pregnant women, there are two specialized programs that are equipped to provide services for the duration of the pregnancy. Six (6) free-standing programs are certified by the DMH, making available a total of twenty (20) primary residential substance abuse treatment programs located throughout the 14 community mental health regions.

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

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

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

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 3% the number of pregnant women who successfully complete treatment during 2019-2020.
2nd year target/outcome measurement:	Increase by 3% the number of pregnant women who successfully complete treatment during 2020-2021.
Data Source:	Annual Monitoring visits, Central Data Repository, and Programs will provide policy and procedures ensuring priority is given to pregnant women. Data from the Addictive Services Point of Service Spreadsheet will also be utilized.
Description of Data:	BBH/AS 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 30% the number of pregnant women that have access to MAT during FY 2019-2020.
2nd year target/outcome measurement:	Increase by 35% the number of pregnant women that have access to MAT during FY 2020-2021.
Data Source:	Annual monitoring visits.
Description of Data:	BBH/AS 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 and State Opioid Response 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 5% the number of IV Drug Users who successfully complete treatment after admission.
2nd year target/outcome measurement:	Increase by 10% 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:	BBH/AS 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:

Increase access to individuals determined to be at high risk for HIV to HIV Rapid Testing & Education services.

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.

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 Behavioral Health/Addictive Services staff through routine monitoring visits.

Indicator #1:	Increase access to individuals determined to be at high risk for HIV to HIV Rapid Testing & Education services.
Baseline Measurement:	Implementation will begin by January 1, 2019.
1st year target/outcome measurement:	Increase by 1% the number of at risk individuals that will receive rapid testing for HIV and Hepatitis during 2019-2020
2nd year target/outcome measurement:	Increase by 2% the number of at risk individuals that will receive rapid testing for HIV and Hepatitis during 2020-2021
Data Source:	Monitoring visits and Annual SABG progress report
Description of Data:	In accordance to the Grant Agreement established between the DMH and the Mississippi Department of Health (MSDH), the MSDH will oversee data collection regarding HIV services. MSDH will collect and report HIV data to the DMH annually or upon request. BBH/AS will continue to 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 annually 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 (Peer Support) Services

Goal:

Increase workforce awareness and understanding of the DMH Operational Standards on Recovery Peer 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 Peer Support Services, BBH/AS will continue to provide technical assistance, programmatic development training, and state-wide provider training to all service providers on what Recovery Peer Support Services is and what it should look like for their community.

Indicator #1:	Increase the number of peer support specialists by 3%.
Baseline Measurement:	Currently there are 60 certified peer support specialists in the state for SUD.
1st year target/outcome measurement:	Increase the number of peer support specialists by 3%.
2nd year target/outcome measurement:	Increase the number of peer specialists by 3%.
Data Source:	Workforce development training database.
Description of Data:	The workforce development division of DMH certifies peer support specialists for the agency.

CRITERION 6: Trauma

Goal:

Increase 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 Behavioral Health/Addictive 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 30 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 Behavioral Health/Addictive Services (BBH/AS) has developed the Co-Occurring Capabilities of Mississippi project.

The BBH/AS 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 BBH/AS conducted 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 BBH/AS to properly categorize each treatment program into one (1) of two (2) primary categories based upon 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 2018-2019, 50% of the CMHCs Co-Occurring Conditions was identified.
1st year target/outcome measurement:	Increase the number of CMHCs to be assessed (DDCMHT) to 60% by the end of grant year 2019.
2nd year target/outcome measurement:	Increase by an additional 70% by the end of grant year 2020.
Data Source:	DDCMHT Scoring Results
Description of Data:	DDCMHT Scoring Results
Data Issues/caveats that affect the outcome measures:	Obtaining the by-in from the CMHCs during the assessment process. Willingness of the provider to embrace the changes needed as a result of the DDCMHT assessment.

CRITERION #8: Prescription Drugs

Goal:

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

Objectives:

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

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

Strategies to attain the objectives:

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

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

BBH/AS 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.

BBH/AS prevention providers will continue to focus available resources on media campaigns and PSAs to assist in education the general public.

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

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:	Reduce past 30 day use of non-medical uses of prescription drugs
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 Behavioral Health/Addictive 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:	To reduce past year non-medical use of prescription drugs.
Baseline Measurement:	In 2015, 4% of Mississippi youths in grades 6-12 reported having used prescription drugs in a way other than how they were prescribed. 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 Behavioral Health/Addictive 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.

Indicator #4:	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 Behavioral Health/Addictive 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:

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

Objectives:

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

Strategies to attain the objectives:

BBH/AS 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:

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

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

BBH/AS 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 Behavioral Health/Addictive 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:

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

BBH/AS 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.

BBH/AS 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 BHAVIORAL HEALTH/ADDICTIVE SERVICES

PROJECTED EXPENDITURES FOR FY 2020

ACTUAL EXPENDITURES FOR FY 2018-2020

FEDERAL/ STATE	FUNDING SOURCE	PROJECTED FY 2020	ESTIMATED FY 2019	ACTUAL FY 2018
Federal	Substance Abuse Block Grant	$13,805,681	$12,704,928	$12,292,757
	MS State Adolescent and Transitional Aged Youth	N/A	N/A	$133,575
	Treatment Enhancement and Dissemination Grant	$300,000	$1,304,202	$1,908,467
	MS Prevention Alliance Communities and Colleges Grant	$500,000	$3,428,665	$3,415,040
	MS State Targeted Response to the Opioid Crisis Grant	$11,500,000	$2,447,345	N/A
	State Opioid Response Grant	$60,000	$175,229	$127,367
	Second Chance Program for Adults w/ Co-Occurring Substance Abuse & Mental Health			
Total Federal		**$26,165,681**	**$20,060,369**	**$17,877,206**
State of MS	3% Alcohol and Liquor Tax	$7,000,000	$7,036,659	$6,140,698
	State General Funds	N/A	N/A	N/A
State Total		**$7,000,000**	**$7,036,659**	**$6,140,698**
Grand Total		**$33,165,681**	**$27,097,028**	**$24,017,904**

Summary

It is the goal of the Mississippi Department of Mental Health-Bureau of Behavioral Health/Addictive 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.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

To enable individuals with mental illness to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the 14 CMHCs offer an array of services. These services include crisis services, which include Mobile Crisis Response Teams (MCeRTS), Psychosocial Rehabilitation Programs, Intensive Community Support Services, Peer Support Services, Supported Employment Services (offered by eleven (11) CMHCs), and PACT Teams (offered by eight (8) CMHCs). In addition, twelve (12) CSUs are available throughout the state to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Housing and support service needs are addressed through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	○ Yes ◉ No
b)	Mental Health	◉ Yes ○ No
c)	Rehabilitation services	◉ Yes ○ No
d)	Employment services	◉ Yes ○ No
e)	Housing services	◉ Yes ○ No
f)	Educational Services	◉ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	◉ Yes ○ No
h)	Medical and dental services	◉ Yes ○ No
i)	Support services	◉ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	◉ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	◉ Yes ○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The CHOICE program is currently available in all CMHC regions, and in FY 2018, 211 assessments were provided. A variety of services are provided to these individuals including outpatient services, peer support, PACT, physician services, community support, intensive case management, and/or psychosocial rehabilitative services,

PACT (Programs of Assertive Community Treatment) Teams include therapists (mental health, substance use and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services. Mississippi currently has ten (10) PACT Teams.

DMH is currently working with Region 2 Community Mental Health Center to pilot an Intensive Community Outreach Recovery Team (iCORT). It is a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults

with severe and persistent mental illness. An iCORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An iCORT is able to target more rural areas where there may be staffing issues and clients are spread out over the geographical area. Services are provided 24-hours per day, 7-days a week just like PACT. DMH received $1 million for community-expansion in our appropriations bill for FY20 with which we add four additional iCORTs. This will allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service.

Regions 6, 8, 9, 13 and 15 operate NAVIGATE programs for youth and young adult experiencing First Episode Psychosis. NAVIGATE teams are Coordinated Specialty Care (CSC) teams of mental health professionals that focus on helping people work toward personal goals and get their life back on track. More broadly, NAVIGATE helps clients navigate the road to recovery from an episode of psychosis, including getting back to functioning well at home, work, and in the social world. NAVIGATE includes four different treatments: individualized medication treatment, family education, individual resiliency training, and supported employment and education.

Wraparound Facilitation is an approach to care planning that builds on the collective action of a committed group of family, friends,
community, professionals, and cross-system supports resources and talents from these various sources result in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies .Currently, twelve mental health providers are certified by DMH to provide Wraparound Facilitation to over 1,700 children/youth annually.

DMH supports 14 Juvenile Outreach Programs to provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center which include immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, and individual therapy.

The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances and complex needs that usually require the intervention of multiple state agencies. On the local level, the DMH provides flexible funding to 56 local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement.

3. Describe your state's case management services

Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. CSS are directed towards adults, children, adolescents and families and vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. Community Support Services include identification of strengths which aid the individual in their recovery, therapeutic interventions that directly increase the acquisition of skills, psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual, crisis prevention, assistance in accessing needed services, relapse prevention and disease management strategies, and facilitation of the Individual Service Plan and/or Recovery Support Plan which includes the active involvement of the individual and the people identified as important in the person's life. Community Support Services must be provided by staff with at least a Bachelor's Degree in a mental health, intellectual/ developmental disabilities, or related field and at least a DMH Community Support Specialist Credential.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Mobile Crisis Response Teams (M-CeRTs) provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. The M-CeRTs target individuals experiencing a situation where the individual's behavioral health needs exceed the individual's resources to effectively handle the circumstances. Without mobile crisis intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. In FY 2018, the MCeRTs made 26,184 contacts. 18,651 of those contacts were face-to-face visits.

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. In FY 2018, 3,513 individuals were served in the CSUs with a 91% diversion rate from inpatient care.

Mississippi currently has ten (10) Programs of Assertive Community Treatment Teams (PACT). In FY 2018, the PACT Teams served 384 individuals and had 145 new admissions.

Certified Peer Support Specialists provide services for individuals with mental illness in their communities with the goal of averting mental health crises by utilizing Personal Outcome Measures (POM), Wellness Recovery Action Plans (WRAP) and Community Asset Mapping. By utilizing this initiative, Mississippi decreases the need for inpatient psychiatric care and increases the number of individuals who attend follow-up appointments.

The Specialized Planning, Options to Transition Team (SPOTT) is a collaboration between DMH and the Arc of Mississippi to support people who have required treatment in inpatient programs on multiple occasions, or who are in crisis and need immediate assistance accessing services. SPOTT's goal is to provide people served through the public mental health system with access to more appropriate, peer supported, and community based choices for care. SPOTT models person-centered processes to support people where they are, one person at a time.

Making a Plan (MAP) Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement. In FY 2018, 55 MAP teams served 881 children and youth.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	160,265	not calculated
2.Children with SED	33,345	not calculated

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Children and Youth
Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious emotional disturbance among children and adolescents in Mississippi. According to URS Table 1, the estimated number of children, ages 9–17 years in Mississippi in 2017 is 370,504. Mississippi remains in the group of states with the highest poverty rate (27.7% age 5–17 in poverty, based on URS Table 1). Therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2017 are as follows:

• Within the broad group (9–11%), Mississippi's estimated prevalence range
for children and adolescents, ages 9–17 years, is 11–13% or from 40,755 – 48,166

• Within the more severe group (5–7%), Mississippi's estimated prevalence range
for children and adolescents, ages 9–17 years, is 7–9% or from 25,935– 33,345

Adults
Uniform Reporting System (URS) Table 1 prepared for SAMHSA by NRI in September 2018 was utilized to calculate the estimate of prevalence of serious mental illness among adults in Mississippi in 2017. URS Table 1 reports that there are 2,257,249 adults in Mississippi (ages 18 years +). According to URS Table 1, the estimated prevalence of serious mental illness among adults in Mississippi in 2017, ages 18 years and above, is 121,891 with a lower limit estimate of 83,518 and an upper limit estimate of 160,265.

Mississippi does not calculate incidence rates. Annually, surveys are sent to all DMH certified community mental health service providers. Included in this data is number of individuals served, among other data, which assists DMH in planning. Additionally, Mississippi obtains data through the Strategic Plan process for which data is submitted quarterly and yields boht a mid-year-and end year progress report. DMH has utilized a goal-based strategic plan to transform the public mental health system in Mississippi. The FY19 – FY21 DMH Strategic Plan includes three goals: To increase access to community-based care and supports through a network of service providers that are committed to a person-centered and recovery-oriented system of care; To increase access to community-based care and supports for people with intellectual and/or developmental disabilities through a network of service providers that are committed to a person-centered system of care; and To ensure people receive quality services in safe settings and utilize information/data management to enhance decision making and service delivery. The Strategic Plan is revised annually and developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan is to create a living, breathing document. The Plan was and continues to be developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Programs of Assertive Community Treatment (PACT) are available 24/7 and do the majority of work with individuals at home, at work or in the community through intensive and diligent outreach strategies. Individuals who meet criteria in rural areas living with severe and persistent mental illness who are not able to benefit from traditional outpatient mental health services can be served through PACT.. Mississippi currently has 10 PACT teams operated by the following Community Mental Health Centers: Warren-Yazoo Behavioral Health, Life Help, Pine Belt Mental Healthcare Resources (operates two in Hattiesburg and Gulf Coast), Hinds Behavioral Health, Weems Community Mental Health Center, Life Core Health Group, Region 8 Mental Health Center, and Timber Hills Mental Health Services (operates two in Desoto and Corinth).

DMH is currently working with Region 2 Community Mental Health Center to pilot an Intensive Community Outreach Recovery Team (iCORT). This team provides a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. The objective is to keep people in the community and avoid placement in state-operated behavioral health programs. An iCORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An iCORT is able to target more rural areas where there may be staffing issues and clients are spread out over the geographical area. Services are provided 24-hours per day, 7-days a week just like PACT. DMH received $1 million for community-expansion in our appropriations bill for FY20 with which we add four additional iCORTs. This will allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service.

Each of the 14 Community Mental Health Centers (CMHCs) developed MCeRTs to provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis including rural areas. The goal is to respond in a timely manner to where the individual is experiencing the crisis or meet the individual at a designated location such as the local hospital. A MCeRT is staffed with a Master's level Mental Health Therapist, Community Support Specialist and Peer Support Specialist.

b. Describe your state's targeted services to the homeless population.

Mississippi has the Projects for Assistance in Transition from Homelessness (PATH) Program which provides services to eligible individuals who are experiencing homelessness and have serious mental illness and co-occurring substance use disorders. The focus has been on individuals who are literally homeless, living in places not meant for human habitation. Peer Support Specialists provide street outreach so workers continually interact with people. Peer Support Specialists used lived experience to help homeless individuals believe that getting out of bad situations is possible and that home, employment, and stability are obtainable. The PATH program provides the state with funds for flexible community-based services for persons with serious mental illnesses and co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. DMH provides funding to 4 CMHC's and 1 non-profit provider to operate PATH Programs.

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.

c. Describe your state's targeted services to the older adult population.

Day service programs are community-based programs designed to meet the needs of adults with physical and psychosocial impairments. There are currently two programs operating in the state. The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets. Additionally, Senior Psychosocial Rehabilitation Programs are offered through the CMHCs and include structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

For the provision of mental health services for adults, financial resources include general/healthcare funds appropriated by the Mississippi State Legislature, Projects for Assistance in Transition from Homelessness (PATH) which is a federal grant program administered by the Center for Mental Health Services, and the CMHS Federal Block Grant for Community Mental Health Services mandated by the U.S. Congress. For the provision of mental health services for children and youth, financial resources include general/healthcare funding appropriated by the Mississippi State Legislature, the CMHS Federal Block Grant for Community Mental Health Services mandated by the U.S. Congress, and Project XPand federal grant funding.

The Department of Mental Health provides web-based training through Relias Learning for registered providers. Relias is a customized learning management system and staff development tool that offers evidenced – based practices training. The Relias Learning training website tracks staff training and eliminates the need for extensive travel to obtain training. In addition, training and technical assistance are provided by DMH staff to certified DMH providers and the general public as requested on topics related to mental illness and substance use disorders. Topics such as suicide awareness and prevention, Adult and Youth Mental Health First Aid, and A.S.I.S.T. are provided to other state agencies, school districts, community colleges and universities, and law enforcement officers and other first responders. Furthermore, professional mental health staff from the community mental health centers (CMHC) provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. Officers from around the state can attend CIT training in Meridian at no cost as a result of a contract between DMH and the Lauderdale County Sheriff's Department.

Training and technical assistance on mental health related topics, the DMH Record Guide, the DMH Operational standards, and service/program implementation is offered to all DMH certified providers upon request. In addition, DMH staff provides trainings in the northern, central, and southern portions of the state to Certified Peer Support Specialists (Adult and Parent/Caregiver). Ethics, confidentiality, and documentation are a few of the topics reviewed in these trainings. National consultants and trainers are utilized as needed to train certified providers on evidenced-based practices and services provided through grants obtained by the Department of Mental Health. Nationally certified Wraparound Facilitation coaches with the Mississippi Wraparound Institute (MWI) at the University of Southern Mississippi provide training, support, and technical assistance to potential and certified providers of Wraparound Facilitation in our state. The Division of Children and Youth Services continues to provide trauma-informed trainings to community and state partners including family members and caregivers.

Regarding the FFY 2019 Federal Block Grant for Community Mental Health Services, Mississippi plans to expend the funding in the following ways:
Administration Amount $298,682
Set Aside $800,000
Amount to be awarded $6,272,319
Children's portion $2,360,006
Adult portion $2,813,631

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

MS DMH- Bureau of Behavioral Health/Addictive Services has developed an interim data collection tool through DataGadget. In this program, bed capacity at all certified facilities will be shown. Data is real-time but entered by hand each time an individual is admitted or discharged. The long-range goal includes the collection of intake and discharge data through the submission of electronic health records to a state-level database system. In addition, sub-grantee funding is withheld from agencies that do not adhere to guidelines.

All SABG-funded programs for women's services are required to respond within 48 hours of seeking treatment. If treatment is unavailable due to a program's insufficient capacity, the program must immediately provide interim services or refer the individual to DMH for assistance.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — ( ) Yes (●) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs — ( ) Yes (●) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

We require all certified providers to give priority to IV drug users. The bed capacity and availability is kept in DataGadget. We identify compliance issue and develop corrective actions based on monitoring visits. A corrective action plan is required for all services not meeting the operational standards to identify compliance issues and develop corrective actions based on monitoring visits. A corrective action plan is required for all services not meeting the operational standards.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — ( ) Yes (●) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — (●) Yes ( ) No
- **c)** Established co-located SUD professionals within FQHCs — (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

A response will be submitted by October 1, 2019.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas — (●) Yes ( ) No
- **b)** Establishment or expansion of tele-health and social media support services — (●) Yes ( ) No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — (●) Yes ( ) No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(●) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	( ) Yes (●) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ( ) Yes (●) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

A response will be submitted by October 1, 2019. 50% of the agencies that are approved for services will be reviewed by the DMH Certification Department.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [x] Other (please specify)

The Mississippi Department of Mental Health Certification Department.
http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf
http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-
http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdfhttp://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-
16.pdf

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Preformance-based accountability ○ Yes ◉ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ○ Yes ◉ No

d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf
http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf
pdfhttp://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? (●) Yes ( ) No

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

none

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

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

As required by the Department of Mental Health's Operational Standards, mental health providers certified by the Department of Mental Health have integrated trauma screening practices into the initial intake assessment process for individuals receiving services. All new cases must have a Trauma Screening with documentation in the case records of individuals receiving services.

The Department of Mental Health, Division of Children and Youth Services continues to provide trauma-informed trainings to community and state partners including family members and caregivers. Since 2006, providers of children and youth mental health services in Mississippi have been trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF

-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). Mississippi also has (3) three National Child Traumatic Stress Network Sites. They are Catholic Charities, Inc., Region 13/Gulf Coast Mental Health Center, and Wilson-Sigrest, LLC. In direct response to the needs from Hurricane Katrina, Mississippi was the first State to have a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) state level Learning Collaborative coming out of National Child Traumatic Stress Network (NCTSN).

In 2014, the Department of Mental Health held its first state-wide Trauma Conference. In addition to cross system training on Trauma- Informed Care, DMH partnered with several state and local agencies to host the annual Mississippi Trauma Informed Care Conference. These annual conferences have brought together more than 600 participants each year. The sessions are inclusive and appropriate for a diverse audience representing mental health and substance abuse professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more. The 6th Annual Trauma Informed Conference will be held September 25-27, 2019 in Jackson, Mississippi.

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

none

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

In September, 2016, Mississippi was awarded a $647,461 federal grant aimed at reducing recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. The Department of Corrections (MDOC) and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders. Region 9, Hinds Behavioral Health Services (HBHS), is the provider for this pilot project.

Program eligibility criteria includes offenders with co-occurring mental health and substance use disorders who score medium-to-high risk for recidivism and are returning to Hinds County for community supervision. Pre-release services include a full array of mental health, substance use, and trauma assessments to determine individuals' needs to inform integrated risk-based treatment and reentry plans. Post-release services are centered around a clinical intensive outpatient program that integrates a correctional curriculum developed by the National Institute of Corrections "Thinking for a Change". MDOC Probation/Parole staff delivers the "Thinking for a Change" sessions during IOP group at Hinds Behavioral. This allows offenders to complete their supervisory reporting without making a special trip to the probation/parole office. This model also creates an interdisciplinary team between HBHS and MDOC to offer full comprehensive support to offenders. In addition to IOP, program participants have access to all of

the services offered at HBHS including medication management, crisis intervention, and recovery support services. Current plans are to serve 90 individuals during the three-year pilot program in order to develop a program model that can be replicated statewide with the receipt of additional federal grant funding.

On April 12 and 13, 2017, a total of 22 individuals participated in the "How Being Trauma-Informed Improves Criminal Justice System Responses" Train-the-Trainer (TTT) Event. Participants included staff from CMHCs, MDOC and the Attorney General's office. The training focused on increasing understanding of trauma, creating an awareness of the impact of trauma on behavior, and developing trauma-informed responses. Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals, and thereby increase safety for all, decrease recidivism, and promote and support recovery of justice-involved women and men with serious mental illness. Partnerships across systems can also help to link individuals to trauma-informed services and treatment for trauma.

The week of June 19-23 2017, 9 MDOC training and mental health/medical staff completed the train-the-trainer event to become certified trainers of MHFA-Public Safety. These staff members will disseminate this 8-hour training each month during mandatory MDOC institutional officer and probation/parole agent refresher training courses as well as throughout the MDOC organization (administration, support staff, offender services and MS CORP stakeholder group.)

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) provides education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers. The officers receive approved continuing education credits from DPS. Additionally, The DMH has entered into a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost to the other law enforcement agencies. The DMH mailed letters, brochures and a video promoting the CIT training opportunity to all 82 sheriff's departments and to 49 of the major police departments around the state. DMH and DPS recognize officers who have completed CIT training by awarding them a certificate from the DMH and DPS signed by Ms. Diana Mikula and Commissioner Fisher, and they get 40 hours of CEs from DPS. In addition to the Lauderdale County CIT program, Region 12, Pine Belt Mental Health, has expanded CIT to Jones, Forrest and Lamar Counties. With funding from SAMHSA, Region 12 also helped initiate CITs in two additional counties, Harrison and Pike. Region IV Mental Health helped establish a CIT program in DeSoto County, with the Sheriff's Dept., Southaven PD, Horn Lake PD, Hernando PD, Olive Branch PD, Walls PD, and Baptist Memorial Hospital.

What began as an effort to develop a collaborative partnership for Juvenile Outreach Programs (JOP) in 2010 has turned into a sustained program that served 1,760 youth in FY18. DMH supports 14 JOP operated by Community Mental Health Centers throughout the state, all of which provide linkage and access to mental health services to youth who are involved in the juvenile justice system. The programs provide assessments, community support, wraparound facilitation, and a number of other services to youth with serious emotional disorders and/or mental illnesses who are in detention centers or the juvenile justice system. The goal for the youth is to improve their behavioral and emotional symptoms, and also to prevent future contacts between them and the youth courts. DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide. A Division of Children and Youth Services staff member also participates on the State Advisory Group for Mississippi under the Juvenile Justice and Delinquency Prevention Act.

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

none

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

In Mississippi, the implementation of MAT has been complex over the past few years. The state is largely rural but also has several areas with large population densities. In addition, the provider community has not received much exposure to the benefits of MAT until 2014 when the SSA strongly encouraged providers to begin dialog with their treatment facilities on the benefits of MAT. Also, BADS is currently receiving technical assistance in the form of a one-year learning collaborative designed to assist programs in implementing and sustaining MAT within their treatment facilities. To date, four programs are involved in the collaborative. Provider education includes webinars, live presentations, conference calls and on-site monitoring.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

e) ☑ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. The DMH funds eight 16–bed CSUs and partially funds one 4-bed CSU, two 8-bed CSUs, and one 12 bed CSU throughout the state.

Additionally, DMH provides funding to the 14 CMHCs to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC's regions. The calls received by the crisis phone line are triaged for severity. Some calls can be handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team. Each CMHC region is required to provide mobile response services in every county they serve. The mobile crisis response teams (MCeRTS) must be able to respond within one hour in an urban area and within two hours in a rural area. The mobile crisis response teams are required to have a Master's level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity. Additionally, if the mobile crisis response team must respond in an area that may not be safe, the will have law enforcement accompany them. A strong working relationship with law enforcement is required through the grant funding. The mobile crisis response team will triage during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with psychiatric care available. The mobile crisis response team is also required to develop working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The "warm-handoff" model is used to facilitate services for the person in crisis with the next provider. Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter "regular" services with the CMHC or other provider. All individuals receiving services at a CMHC who have recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMHC staff and any significant others the individual wants involved. As part of the crisis response system, the CMHC's are required to develop a multi-disciplinary assessment and planning team (MAP Team) made up of all the agencies that work with the most well-known individuals in the community. The MAP teams usually consists of mental health, health, human services, police department, sheriff's office, chancery clerk, faith based ministries, housing, etc., to develop a plan for the individuals in their community which consume the most time from all these agencies. The MAP Teams are encouraged to find an alternative to continually committing the same individuals over and over to one of the state behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff's Office to develop Crisis Intervention Teams (CIT)) across the state. The Lauderdale Sheriff's Office is a training site for officers from anywhere in the state to come for the 40-hour training required to be a CIT officer. The local CMHC is fully involved in the curriculum development and presentation. The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions.

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

none

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(●) Yes	( ) No
b)	Required peer accreditation or certification?	(●) Yes	( ) No
c)	Block grant funding of recovery support services.	( ) Yes	(●) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(●) Yes	( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The Recovery-Oriented System of Care model is designed to support individuals seeking to overcome mental health disorders and substance use disorders across their lifespan. The service components of the Recovery-Oriented System of Care model include: consumer support services, outpatient services, crisis response services, community living options, identification and outreach, psychosocial rehabilitation services, supported employment, family/consumer education and support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance use are also included in the system of community-based care.

The Mississippi Department of Mental Health has adopted the philosophy that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented as highlighted in the Mississippi Board of Mental Health and Mississippi Department of Mental Health Strategic Plan. The FY18 – FY19 DMH Strategic Plan includes objectives focused on utilizing peers and family members to provide varying supports to assist individuals in regaining control of their lives and their recovery progress. These objectives are met through the Certified Peer Support Specialist Program, recovery-oriented system of care trainings, Personal Outcome Measures (POM), and other activities. The Plan also includes strategies to increase the use of Wellness Recovery Action Plans (WRAP). DMH administers the Certified Peer Support Specialist Program for people who have lived experience of mental illness and/or substance use disorder and/or family members who want to provide peer recovery services to others. In addition, the Think Recovery awareness campaign is helping to move the public mental health system towards a recovery-oriented system of care.

Recovery is based on the involvement of consumers/peers and their family members. Efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health system include: (1) Planning Services – Consumers and family members have an opportunity for meaningful participation on planning councils, task forces and work groups on a state, local, and national level; (2) Delivery of Services – Consumers and family members are employed as Certified Peer Support Specialists; and (3) Evaluation of Services – Consumers and family members have an opportunity to participate on personal outcome measure interviews using the Council on Quality of Life Personal Outcome Measures. The personal outcome measure interviews provide an opportunity for consumers and family members, through a guided conversation, to evaluate quality of life. Consumers and Family members, on a local level are involved in consumer and family satisfaction surveys.

The DMH sponsors meetings with peer support specialists and certified peer support specialists to discuss the role of peer support and barriers to provision of peer support services within the behavioral health service system. The DMH also sponsors Mental Health Planning Councils and various task forces, work groups and committees as an avenue to address issues and needs regarding the behavioral health service system.

Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning; shared decision making; and direct their ongoing care through the Breakthrough Series. The DMH provides trainings to peer specialists and is working with advocacy groups, consumers and family members to develop a system that affords consumers and family members the opportunity for meaningful participation in treatment, service delivery system, etc.

The DMH's Peer Support Specialist Program began in 2012. In FY 2018, 160 peers and family members were trained as Certified Peer Support Specialists and 42 DMH certified providers employed 230 Certified Peer Support Specialists. Certification is required for Peer Support Specialists in Mississippi, which leads directly to employment opportunities. Three designations exist for CPSSs in Mississippi: Certified Peer Support Specialist – Adult (CPSS-A), Certified Peer Support Specialist – Parent/Caregiver (CPSS-P), and Certified Peer Support Specialist – Young Adult (CPSS-Y). All Certified Peer Support Specialists (CPSS) are supervised by a CPSS who has completed the State Certified Peer Support Specialist Supervisor Training. This training is provided at least twice a year at no expense to participants. CPSSs in Mississippi are employed in a variety of settings including crisis services, housing and employment programs, homeless programs, drop-in centers, psychosocial rehabilitation programs, and inpatient services. The state financially supports an annual Certified Peer Support Summit which provides CPPSs an opportunity to stay connected to each other, share concerns, learn from one another's experiences, and stay informed about upcoming events and activities. DMH also supported the development of and continue to support the operation of the Association of Mississippi Peer Support Specialists (AMPSS).

CPSSs are trained with the DMH Certification Team to conduct certification visits of DMH certified providers. On the certification visits, CPSSs conduct interviews with CPSSs, CPSS supervisors and other CMHC staff members and review Recovery Support Plans

and supporting documentation to evaluate the progress of providers toward a person centered, recovery-oriented system of care and the integration of peer support services into the behavioral health system. Additionally, DMH staff, in conjunction with CPSSs, conduct training on Recovery-Oriented Assessment, Individual Service Planning and Progress Note documentation, Language of Recovery, Environment of Recovery, and Share Your Story to DMH Certified Providers. CPSSs also participate in an interview process and Train the Trainer to participate in Recovery-Oriented System of Care technical assistance and training opportunities.

Personal Outcome Measures (POM) are a powerful tool for evaluating personal quality of life and the degree to which providers individualize supports to facilitate outcomes. The results from POM interviews give a voice to people receiving services. All CMHCs in the state participate in the POM interview process. The data is compiled and utilized to strengthen Mississippi's efforts to transform to a person centered, recovery-oriented system of care.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery Support Services for individuals with substance use disorders are non-clinical services that are offered before, during and after any services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal, and other resources that facilitate recovery and wellness to reduce or eliminate environmental or personal barriers to recovery. RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families. This service requires a twelve (12) month step down approach. Emphasis is placed on the "critical time" of the first six (6) months of service. In the first 3 months of treatment, requirements include face to face contact for a minimum of one hour weekly, community involvement such as 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery, weekly random drug screes, and weekly family contact . The subsequent three (3) months include face to face contact for a minimum of one hour every other week, continued community involvement, monthly random drug screens; and family contact as needed. For the remaining 6 months, Recovery Support staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts. Recovery Support staff must maintain on site a comprehensive file of existing community resources. Recovery Support Staff must develop an annual plan for conducting community outreach activities that must include: each county in their catchment area, an emphasis on alcohol and other drug treatment and prevention services offered by their organization, a minimum of twelve (12) community activities per year and cannot be limited to exhibits or booths at community events, and identification of targeted community health providers, areas or populations such as workplaces of young adults, physicians, drug courts, etc.

5. Does the state have any activities that it would like to highlight?

n/a

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

none

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Mississippi Department of Mental Health (DMH) Strategic Plan is a living document depicting the direction the Department is taking to meet the goals and changing demands of mental health care in Mississippi. Through the outcomes in the DMH Strategic Plan, our goal is to inspire hope, assist people on the road to recovery, and improve resiliency, to help Mississippians succeed. Goal 1 sets forth DMH's vision of people receiving services having a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. This goal highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, Goal 1 emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long-term community supports and other specialized services to help people transition from inpatient care to the community and help people remain in the community. The activities highlighted below are addressing community integration as required by the Olmstead Decision of 1999 and are included in DMH's strategic plan and annual reports.

Housing

Multiple agencies, including development authorities, housing corporations, regional housing authorities, state departments, federally funded contractors and local contracted providers have a role in providing housing and supportive services for individuals with disabilities and life challenges in the State of Mississippi. The Creating Housing Options in Communities for Everyone (CHOICE) program, funded by the State of Mississippi, is a partnership between Mississippi Home Corporation, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and the 14 Community Mental Health Centers (CMHCs). The CHOICE program provides independence to persons with serious mental illness through stable housing via rental assistance,

with supportive mental health services through Integrated Supportive Housing. CHOICE participants are assisted by priority. Priority 1 individuals are those that are being discharged from a state psychiatric hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities after a stay of more than ninety (90) days. Priority 2 individuals are those who have been discharged from a state psychiatric hospital within the last two (2) years and have had multiple hospital visits within the last year due to mental illness, are known to the mental health or state housing agency to have been arrested or incarcerated in the last year due to conduct related to mental illness or who are known to have been homeless for one (1) full year or have had four (4) episodes of homelessness in the last three (3) years. Priority 3 individuals are those who lack a fixed, regular, and adequate nighttime residence and/or who are exiting from an institution where they resided for ninety (90) days or less and who resided in emergency shelters or places not meant for human habitation immediately before entering that situation.

Mobile Crisis

All 14 CMHCs have developed Mobile Crisis Response Teams (MCeRTs) to provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. MCeRTs work hand-in-hand with local law enforcement, Chancery Judges and Clerks, and the Crisis Stabilization Units to promote a seamless process. The Teams ensure an individual has a follow-up appointment with his or her preferred provider and monitor the individual until the appointment takes place. Without mobile crisis intervention, an individual experiencing a crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital, or inpatient treatment program. The goal is to respond in a timely manner to where the individual is experiencing the crisis or meet the individual at a designated location such as the local hospital. A MCeRT is staffed with a Master's level Mental Health Therapist, Community Support Specialist and Peer Support Specialist.

Peer Support

DMH partnered with Certified Peer Support Specialists (CPSSs) across the state to develop the Think Recovery campaign to help increase the knowledge of service providers and individuals on the Components of Recovery. The campaign engaged consumers in the planning, development and implementation of the campaign. The campaign highlights the importance of community integration and focuses on sharing personal stories of recovery. CPSSs have been included on Mobile Crisis Response Teams, PACT Teams, Supported Employment pilot sites, and other areas throughout the public mental health system. A CPSS is an individual or family member of an individual who has self-identified as having received or is presently receiving behavioral health services. A CPSS has successfully completed formal training recognized by DMH and is employed by a DMH Certified Provider. These individuals use their lived experiences in combination with skills training to support peers and/ or family members with similar experiences. Mississippi began the CPSS program in 2012 and has 230 active CPSSs as of the end of FY18. CPSSs are employed at all of the DMH operated behavioral health programs for adults. The ?rst CPSSs with a designation of a Parent/Caregiver completed their training at DMH in March 2017. The Parent/Caregiver designation is an expansion of the CPSS Program. Although Mississippi has a successful CPSS training program geared toward adults in recovery, this new designation of peers focuses on those who will be working with children with behavioral health issues. The training is a customized, two-day block within the current CPSS training program.

Community Transition Homes

DMH, Region 8 Community Mental Health Center, Hinds Behavioral Health Services, and The Arc of Mississippi have partnered to provide community-based living opportunities for individuals that have been receiving continued treatment services at Mississippi State Hospital. Region 8 began a Community Transition Home for four females in Simpson County in April 2018 and has added an additional house for four more females. Region 9 began a Community Transition Home in May 2018 for four males in the Jackson area. These individuals have been unsuccessful living in the community in the past. Now, with 24/7 support and assistance, the individuals pay their own rent, purchase their own food and participate in community.

MOU with Medicaid

A Memorandum of Understanding between DMH and the Division of Medicaid (DOM) is easing the transition process for people who have received services at DMH's state hospitals. Implemented on July 1, 2018, the MOU has three core components:

1) DMH social workers can now submit applications for people who are receiving services in the state hospitals. Previously, DMH staff would only assist with this process close to the patient's discharge date, since Medicaid cannot provide benefits to someone while they are in a DMH hospital. If the application is approved before discharge, those benefits will still be restricted until after discharge.

2) People who receiving Medicaid benefits prior to admission at a DMH hospital will retain their enrollment in the Medicaid program, but restrictions will apply while they are receiving inpatient services at a DMH hospital. Those restrictions will be lifted at discharge, and the patient will not have to complete the Medicaid application process again.

3) Benefits will be unrestricted if the patient, while still in the care of DMH, requires additional inpatient treatment at another medical program. This unrestricting allows Medicaid to provide reimbursement for qualifying medical needs while the patient will be returning to a DMH hospital.

PACT Teams

In FY19, DMH provided funding for two additional PACT Teams - Region 8 Mental Health Center and Timber Hills Mental Health Services. Mississippi currently has 10 PACT teams operated by the following Community Mental Health Centers: Warren-Yazoo

Behavioral Health, Life Help, Pine Belt Mental Healthcare Resources (operates two in Hattiesburg and Gulf Coast), Hinds Behavioral Health, Weems Community Mental Health Center, Life Core Health Group, Region 8 Mental Health Center, and Timber Hills Mental Health Services (operates two in Desoto and Corinth).

Supported Employment
DMH researched best practices and chose the Supported Employment Programs of Individual Placement and Support (IPS). Supported Employment, an evidenced-based way to help people diagnosed with mental illnesses secure and keep employment, begins with the idea that every person with a serious mental illness is capable of working competitively in the community. In FY18, there were four Supported Employment sites, Region 2, 7, 10, and 12. To help expand the programs, in the second quarter of FY19, DMH provided funding to Community Mental Health Centers to add seven more Supported Employment programs at Region 3, 4, 8, 9, 11, 14, and 15. Currently, there are 11 Supported Employment programs across the state. DMH has developed a MOU with Department of Rehabilitative Services to assist with training and job placement.

Bed Tracking System
A bed dashboard has been created for crisis and community beds. CSUs and CMHCs update their bed status daily when they run their daily census. In the third quarter of FY19, DMH received a grant from NASMHPD to enhance the bed registry tracking system. This project will be on-going until September 2019.

Transitions
DMH has established a Transition Workgroup with representatives from state hospitals, community providers, peer specialists, and Central Office to make recommendations to improve the transition process for people leaving the state hospitals. DMH is partnering with the Department of Health to increase the awareness of the connection between chronic disease and mental health. The goal is to help improve physical health and mental health outcomes for people who have a chronic disease as they transition to the community.

Crisis Intervention Teams
Crisis Intervention Teams are partnerships between local law enforcement agencies and a variety of agencies, including Community Mental Health Centers, primary health providers, advocacy groups such as NAMI, and behavioral health professionals. Officers joining a team learn the skills they need to respond to people experiencing a mental health crisis and divert them to an appropriate setting for treatment, ensuring people are not arrested and taken to jail due to the symptoms of their illness. Fully-operating Crisis Intervention Teams are now in Hinds County CIT, Northeast Mississippi CIT, Pine Belt CIT, Pike County CIT, and the Northwest Mississippi CIT. Stakeholders in Harrison County and Warren County are also taking steps to establish a CIT.

Drop-In Centers
Region 9 Hinds Behavioral Health Services opened a new drop-in center on May 15. The center provides a wide variety of services to help homeless individuals with serious mental illness gain access to housing, treatment, and recovery support. Peers help individuals build social skills, self-confidence, self-advocacy, and support systems. The drop-in center also provides access to basic needs such as food, showers, toiletries, clothes, laundry, telephones, and mail. Individuals may voluntarily drop-in and participate in activities or use any of the center's services. Mississippi currently has drop-in centers in Harrison, Jackson, and Hinds counties with hopes to expand an additional center in Forrest County.

Integrated Care Grant
DMH received a grant for the Integration of Primary and Behavioral Healthcare in Region 12 and region 9. DMH is partnering with the CMHCs and Federally Qualified Health Clinics to co-locate services.

Intensive Community Outreach Recovery Team (iCORT)
DMH is currently working with Region 2 Community Mental Health Center to pilot an Intensive Community Outreach Recovery Team (iCORT). It is a recovery and resiliency oriented, intensive, community-based rehabilitation service for adults with severe and persistent mental illness. The objective is to keep people in the community and avoid placement in state-operated behavioral health programs. An iCORT has fewer staffing requirements and higher staff client ratios than a traditional PACT Team. An iCORT is able to target more rural areas where there may be staffing issues and clients are spread out over the geographical area. Services are provided 24-hours per day, 7-days a week just like PACT. DMH received $1 million for community-expansion in our appropriations bill for FY20 with which we add four additional iCORTs. This will allow the CMHCs that can't sustain a PACT Team, the opportunity to provide a similar intensive service.

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

none

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ( ) Yes (●) No

b) Costs? ( ) Yes (●) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

DMH was awarded a Cooperative Agreement to begin October 1, 2017, which focues on youth who are involved with the child welfare and/or juvenile justice systems, referred to as “crossover youth”. The Crossover XPand SOC project expands current and graduated System of Care (SOC) programs in two jurisdictions served by Pine Belt Mental Healthcare Resources and Weems Community Mental Health by prioritizing underserved children and youth who are involved in the child welfare/advocacy system and/or the juvenile justice system, referred to as "crossover youth," and those at risk for becoming crossover youth, and their families. The priority children and youth have a diagnosed serious emotional disorder (SED), co-occurring disorder (COD), or first episode of psychosis (FEP), are ages 3 -21, reside in Forrest, Jones, Lauderdale, or Marion Counties in Mississippi, and are involved with child protection services and/or juvenile justice, or are at risk for involvement.

The goals of Crossover XPand SOC are: 1) to expand Mississippi's SOC by targeting at risk and crossover youth (ages 3-21) with SED/COD/FEP and their families and expanding integrated care with evidence-based interventions; 2) to increase awareness of, and community commitment to, the mental health issues of at risk and crossover youth; 3) to improve organizational and systemic capacity to serve at risk and crossover youth with SED/COD/FEP across five levels of care; 4) to expand youth and family roles as full and equal partners within an integrated system of care; and 5) to use continuous quality improvement to drive and sustain effective service delivery for replication. Crossover XPand SOC will annually engage a minimum of 100 at risk or crossover youth,

for a total of 400 youth over the entire project period. Other objectives include improving time to engage youth by integrating services at strategic intercept points, expanding access to care, and creating a skilled trauma-focused workforce.

Fourteen (14) Juvenile Outreach Programs provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The programs provide for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need. The DMH, Division of Children and Youth Services staff also actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide.

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county child protection services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process.

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

n/a

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

none

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The Mississippi Department of Mental Health (DMH) established the state's first Suicide Prevention Workgroup in April 2016 to develop the state's first Suicide Prevention Plan which was released in September 2016. The three-year plan formalized suicide prevention efforts already taking place in the state and set a series of goals and objectives to accomplish over the course of the three year plan. Since its inception, DMH has released two Progress Reports documenting accomplishments made in FY 2017 and 2018. The Plan and Progress Reports can be viewed at http://www.dmh.ms.gov/resources/ under "Suicide Prevention". An FY 2019 Progress Report will be available in September 2019.

Over the last fiscal year, DMH and statewide partners have worked diligently to make progress with the objectives in the plan. From July 1, 2018 to May 31, 2019, there were 99 presentations made reaching 11,078 people. Information included risk and protective factors, warning signs, and referral information. These presentations included 75 of the state's suicide prevention campaign, Shatter the Silence, made to 10,547 participants. In September 2018, DMH received a Mental health Awareness Training (MHAT) Grant from SAMHSA that has allowed DMH to provide Youth Mental Health First Aid training to educators, school resource officers, and parents/caregivers across Mississippi. As a result of this grant, DMH has trained 203 people as Mental Health First Aiders. An additional 106 people were trained outside of the MHAT grant in Mental Health First aid, 150 people were trained in Psychological First Aid, and 72 people were trained in Applied Suicide Intervention Skills Training (ASIST). Mental health and crisis resources that include the National Suicide Prevention Lifeline as well as DMH's Helpline have been distributed to each person who receives Shatter the Silence, Mental Health First Aid and ASIST training.

In 2019, DMH collaborated with the Mississippi Department of Public Safety (DPS) to develop a Shatter the Silence presentation that resonates with Highway Patrol Officers. The presentation garnered the support of the Commissioner of Public Safety and Highway Patrol officers and has been presented to the Highway Patrol Trooper School's 62nd class during their reunion in March and to the 63rd class during their graduation in May. Plans are in motion for Troop Leaders to be trained in Shatter the Silence to help spread the message among their Troopers, and in their communities. A version of Shatter the Silence was also developed for the Mississippi National Guard who invited DMH to participate in their Yellow Ribbon events for soldiers returning from active duty and their family members. Finally, Pinelake, a church with 5 campuses statewide, has collaborated with DMH to develop a youth and adult faith-based version of Shatter the Silence. Campus ministers will be trained in August as train the trainers of Shatter the Silence to share the message with both youth and adult church members.

During the 2019 Legislative session, the Mississippi Legislature passed House Bill 1283, the "Mississippi School Safety Act of 2019." As part of the legislation, the Mississippi Department of Education shall establish three pilot sites in six school districts utilizing an evidence-based curriculum to provide students in K-5 with skills to manage stress and anxiety. DMH will be responsible for the selection of the content of the curriculum and will develop a focus group in the fall of 2019 to select the content. The results of the program shall be measured and reported, and such results shall be used in consideration of statewide implementation. Additionally, to increase understanding of mental health and suicide, the comprehensive local school district safety plans, beginning in the 2019-2020 school year, shall be required to include refresher training on mental health and suicide prevention for all school employees and personnel. DMH shall be responsible for the development and/or selection of the content of the training and will develop a focus group to select the content, and districts will report completion of the training to the Mississippi Department of Education. Finally, effective in the 2019-2020 school year, DMH shall develop a standardized MOU to be utilized by DMH certified providers and mental health facilities in providing mental health services to local school districts which will include standardized screening and referral protocols, procedures, and forms to be utilized by the local school districts. DMH will provide online training for appropriate school personnel to conduct initial behavioral health screenings of students experiencing or exhibiting behavioral stress or at risk of harming themselves or others.

3.	Have you incorporated any strategies supportive of Zero Suicide?	○ Yes	● No
4.	Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?	● Yes	○ No
5.	Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?	● Yes	○ No

If so, please describe the population targeted.

South Mississippi State Hospital, a Behavioral Health Program in Purvis, MS developed a Choosing to Live suicide prevention group that involves patients who are either at risk for suicide. The group discusses reasons for living, breaks down the stigma around mental illness, and helps patients with safety planning. The group developed a "Coping Card" that is a template that identifies reasons for living, but also coping strategies that the person can take when they are in a mental health crisis. The patients share coping skill ideas with one another, and work on ways to deal with a suicidal crisis like social supports and distractions. The idea has been encouraged to be implemented at other state Behavioral Health Programs.

The state's first three-year suicide prevention plan is near the end of its final year, and has goals and objectives slated for the FY 2020- FY2022 plan that will expand upon existing collaboration with the MS Department of Public Safety, MS Army National Guard, and Pinelake Church.

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

none

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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

DMH was selected to participate in the Southeast School Mental Health Learning Community to focus on the implementation of multi-tiered systems of school mental health support with a special emphasis on integrating school mental health into state and district school safety planning. This is an opportunity for a team of leaders from each state to receive a one-day in-person training from national experts on comprehensive school mental health systems, connect with other leaders in the Southeast region that are working on school mental health, and participate in online learning sessions. Mississippi's team is comprised of two DMH staff, two Mississippi Department of Education staff, and two school district staff. To increase awareness, DMH partnered with the Mississippi Department of Education (MDE) to offer web-based suicide prevention training to all school district staff. As a result of HB 263 passed during the 2017 Legislative Session, two professional development series were selected for all certified and classified school district staff to complete during the 2017-2018 school year. DMH gathered a focus group consisting of school professionals, people affected by suicide, mental health professionals, and others to provide input on the course selection. School districts are to report implementation of the trainings to the Mississippi Department of Education. At the end of FY18, MDE reported that 60,197 school district staff have been trained in suicide prevention, with 26 districts left to report. Also, as a result of HB 263 that was passed in the 2017 Legislative, DMH was responsible for developing a model policy template for school districts. According to the law, all school districts are required to adopt a policy for suicide prevention. A template was developed through focus group participation and provided to MDE for implementation. School districts are monitored by MDE for assurance that the policy is adopted within the district. DMH is always open to and welcomes opportunities to partner with other agencies. As seen throughout the MHBG Block Grant application, DMH currently partners with the Division of Medicaid (Office of the Governor), Mississippi Department of Human Services, Mississippi Child Protection Services, Mississippi Department of Health, Mississippi Department of Education, Mississippi Department of Corrections, Disability Rights, Mississippi National Guard, Mississippi Attorney General's Office, Mississippi Board of Pharmacy, Mississippi Bureau of Narcotics, Mississippi Public Health Institute,

University of Mississippi Medical Center, Mississippi Department of Public Safety, the ARC of Mississippi, Southern Christian Services for Children and Youth, Vicksburg Family Development Center, Families As Allies for Children's Mental Health, Inc., Canopy, Mental Health Association of the Gulf Coast, Gulf Coast Women's Center for Non-Violence, NAMI Mississippi, Mississippi United to End Homelessness (MUTEH), Mississippi Home Corporation, the Association of Mississippi Peer Support Specialist, the 14 CMHCs and all other DMH certified providers of mental health services. DMH also works closely with the institutions of higher learning in our state including the University of Mississippi, Mississippi State University, Jackson State University, Belhaven University, Alcorn State University, and the University of Southern Mississippi.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care. Representatives from various State agencies participate on the Mississippi State Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc.

The Mississippi Department of Mental Health's campaign Operation Resiliency in partnership with the National Guard aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress, and share knowledge about available resources. Stress can be a part of everyday life for many people. However, members of the military can face a constant and severe stress that many civilians may never know. It can lead to depression, anxiety, relationship problems, aggression, thoughts of suicide, financial problems, accidents, alcohol and drug use, domestic violence, and hopelessness.

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers. The officers receive approved continuing education credits from DPS. The DMH has a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost. In addition, the Department of Corrections and DMH are partners in administering the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorder. Funded by a federal grant, this partnership between the Department of Mental Health and the Department of Corrections aims to reduce recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. It allows the two departments to improve identification of inmates with co-occurring substance use and mental health disorders, provide training to staff, integrate individualized treatment plans and track participant outcomes. The program focuses on people returning to Hinds County.

DMH is excited to partner with NAMI Mississippi and System of Care sites to bring together young people throughout our state to empower them to use their voice to ensure quality mental health care services that achieve positive and lasting mental wellness for all Mississippians. Open Up Mississippi is a youth-led, statewide advocacy council with the mission to engage youth and young adults as they break down barriers to gain mental wellness and utilize their strengths against the stigma of mental health. By using their voices, the goal is to seek to remove the stigma and stereotypes that prevent people from seeking mental health services.

Programs that provide services for children with mental health needs are available and accessible in the regular education setting as well as the special education arena. In Mississippi, there are fourteen (14) Community Mental Health Centers (CMHC), with each location being responsible for provision of services to local school districts certified by the Mississippi Department of Education via interagency agreements. All 14 CMHCs are required to have interagency agreements with each local school district in their region. As a result of this agreement, over 20,000 students with emotional, behavioral, or mental health challenges received mental health services in the schools in FY 2018. Statewide initiatives such as those on suicide prevention, bullying, and cybercrimes (sexting) have also played a large role in providing assistance to all students to prevent inpatient stays and residential institutionalization.
In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate Mississippi Department of Education accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning. Section 504 Teacher Units are also approved through the Department of Education to local school districts for community residential programs for adolescents with substance use problems and other areas under Section 504 criteria. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. Children with serious emotional disturbance who meet eligibility criteria for a disability in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. A free appropriate public education (FAPE) must be

available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP). After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment.

Recently, a federal grant from the Substance Abuse and Mental Health Services Administration awarded in 2018 has enabled DMH to offer mental health training and education to schools and educators throughout the state. Mississippi's Mental Health Awareness Training Project is increasing mental health literacy in all school districts by offering training educators, school resource officers, parents, and caregivers in Mental Health First Aid. DMH is partnering with the Mississippi Department of Education's Office of Safe and Orderly Schools to reach school resource officers in the state. These officers are local law enforcement agents who are responsible for the safety of students and staff while on school grounds and involved in school activities. Through the MHAT Project, DMH will provide training in Mental Health First Aid for Youth to educators and parents.

Students Ruled EmD under the Individuals with Disabilities Education Act of (2004)
IDEA 2004 defines emotional disturbance as a condition in which a child exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: inability to learn that cannot be explained by intellectual, sensory or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behavior or feelings under normal circumstances; general pervasive mood of unhappiness or depression; and/or tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia and does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance. The Division of Parent Outreach within the Mississippi Department of Education, Office of Special Education (OSE), provides information and training in areas of identified need to parents, students, and community organizations. This division works to build collaborative relationships with parents and organizations interested in services to children with disabilities. This division also provides the following: training regarding parental rights and services under IDEA 2004; development and distribution of materials for parents; handling of parent complaints, mediation, Resolution Sessions, and due process hearings; and conducting meetings with stakeholders. The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling. Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses counseling, psychological services and the needs assessment. One of the eight components of the Center for Disease Control and Prevention's (CDC) coordinated school health is counseling and psychological services. In accordance with this component, Mississippi public schools are required to establish a local school wellness policy.

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 Mississippi United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings. In 2015, the Mississippi Home Corporation received funding from the Mississippi Legislature to partner with DMH to develop an integrated permanent supported housing project. This will ensure people with a serious mental illness who are housed as a result of permanent supportive housing have the opportunity to live in the most integrated settings in the community of their choice by providing an adequate array of community supports/services. This program began implementation in March 2016 known as CHOICE, Creative Housing Options in Communities for Everyone.

DMH, Region 8 Community Mental Health Center, Hinds Behavioral Health Services, and The Arc of Mississippi have partnered to provide community-based living opportunities for individuals that have been receiving continued treatment services at Mississippi State Hospital. Region 8 began a Community Transition Home for four females in Simpson County in April 2018; with plans to add an additional house for four more females in the near future. Region 9 began a Community Transition Home in May for four males in Jackson area. These individuals have been unsuccessful living in the community in the past. Now, with 24/7 support and assistance, the individuals pay their own rent, purchase their own food and participate in community.

"Bridging the Gap" started at South Mississippi State Hospital (SMSH) as a series of quarterly meetings that included outpatient providers and other service agencies in the 15-county SMSH catchment area, where the hospital provides services. The hospital invited legislators, chanceries, and local law enforcement to participate so everyone could get a better knowledge base about mental health services available in the community. The program grew quickly and has evolved into a quarterly resource sharing session that provides an important communication tool for SMSH staff and community service providers as they locate resources and services for people as they are discharged from the hospital. In 2018, the program was replicated at North Mississippi State Hospital in Tupelo, East Mississippi State Hospital in Meridian, and Mississippi State Hospital in Rankin County. The meetings help ensure continuity of care for adults transitioning from the hospitals back into the community. Community Mental Health Center staff and hospital staff get to discuss patient care directly, including conversations about medication efficacy, new service programs, and how clients sustain recovery in the community

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

none

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Division of Alcohol and Drug Services is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems. The overall goal of the state's alcohol and drug service system is to provide a continuum of community-based primary and transitional residential treatment, inpatient and recovery support services.

The Councils for Alcohol and Drug Services and Mental Health are not combined at this time. However, two representatives from the Alcohol and Drug Services Advisory Council also serve on the Mental Health Planning and Advisory Council. The Bureau of Behavioral Health Services and the Division Alcohol and Drug Services work together in developing the State Plan.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The members of the Mississippi State Mental Health Planning and Advisory Council make comments to and approve the MHBG application/FY 2020-2021 Mississippi State Plan for Community Mental Health Services. Council members serve as advocates for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses through promotion and assistance in planning and developing comprehensive mental health treatment, support, and rehabilitation services for these individuals. The Council also monitors, reviews, evaluates, and advises the allocation and adequacy of mental health services within the state.

The Planning Council members and committees are asked to identify topics they want information on following each Planning Council meeting. The topics addressed at each meeting are based on the Council members' requests. In 2019, the Planning Council met: February 7, 2019, May 2, 2019, and August 1, 2019. The next meeting is scheduled for November 7, 2019. At each meeting, the Council is consistently informed of the status of the Department of Mental Health's budget.

The Council members receive information on the application instructions for the draft and final report provided by SAMHSA. The

process to make a Draft Plan available for review by the Council and the public has proceeded along timelines to allow sufficient time for public review and comment in compliance with the federal submission timeline.

The Council received reports on the major initiatives planned for FY 2020-2021 at the August meeting. The State Plan Draft was presented to the Council at the August meeting. The public comment period was August 12, 2019, through August 30, 2019. The Council also has the opportunity for review of the FY 2020-2021 State Plan Draft during that time.

Public notices of the availability of the Draft Plan for public review and comment are made available at the 14 regional community mental health centers across the state, the East MS State Hospital in Meridian, the MS State Hospital in Whitfield, the North MS State Hospital in Tupelo, the South MS State Hospital in Purvis, the Central MS Residential Center in Newton, the five regional centers for persons with intellectual developmental disabilities, the Specialized Treatment Facility and the Mississippi Adolescent Center operated by the Department of Mental Health and on the MS Department of Mental Health's website. A Draft Plan was sent directly to the directors of the community mental health centers and the Department of Mental Health facilities asking them to make the Plan available to their employees and other interested individuals in their area of the state. The Draft Plan is also sent to all members of the MS Planning and Advisory Council.

In addition to those entities listed in the public notice, the Draft Plan and requests for review, comment, and assistance in making the Plan accessible for review and comment is sent directly to Governor Phil Bryant and the directors of the following agencies:

MS Department of Education
MS Department of Health
MS Department of Child Protection Services
MS Department of Human Services
MS Department of Human Services, Division of Aging and Adult Services
Disability Rights Mississippi, Inc.
MS Department of Rehabilitation Services
MS Institutions of Higher Learning
Office of the Governor, Division of Medicaid
Mississippi Development Authority
Department of Psychiatry and Human Behavior, University of MS Medical Center
MS Primary Health Care Association
Melody Worsham, Certified Peer Support Specialist

Although some non-service representatives on the Planning Council are also members of NAMI chapters, Mental Health Associations and/or Families As Allies for Children's Mental Health, Inc., additional copies of the Draft Plan and requests for comment are also sent to directors, presidents, or other leadership of state and local affiliates of the following family/consumer/advocacy groups:

Families As Allies for Children's Mental Health, Inc.
Mental Health Association of Mississippi
NAMI Mississippi

The Planning Council continues to be expanded to include representatives of all populations. Several African Americans, senior adults, a representative from the VA Medical Center, and a representative from the Mississippi Band of Choctaw Indians are members of the Council.

The MS Department of Mental Health Community Mental Health Services FY 2020-2021 Behavioral Health Report is reviewed and approved by the Mississippi State Mental Health Planning and Advisory Council before submission.

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

none

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

MH and SA have two separate Advisory Councils. The minutes for the last SA Advisory Council Meeting held July 11, 2019 is uploaded (upload date 9/26/2019)

Awaiting SPO, Spencer Clark's, feedback on whether the following two sections: Advisory Council Members and the Advisory Council Composition by Member Type sections need to be complete by SA also.

Mississippi State Mental Health
Planning and Advisory Council Meeting

Agenda
Thursday, August 1, 2019

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (May 2, 2019)

3. Old Business

4. New Business

   A. DMH Budget Update
      Wendy Bailey – Mississippi Department of Mental Health
      Chief of Staff

   B. FY 2020–2021 MHBG Application/State Plan Update
      Lynda Stewart – Mississippi Department of Mental Health
      Division of Children and Youth Services

   C. CIT Expansion Efforts in South Mississippi
      Linda Foley – Pine Belt Mental Health
      Major Jamie Tedford – Jones County Sheriff's Department

   D. New/Additional Mental Health Services for Adults
      Natalie Blackmon, Sherry Holloway, Brent Hurley –
      Mississippi Department of Community Services

   E. Announcements

   F. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
August 1, 2019
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chair

A. Opening

Council Chair, Mr. Connell, called the meeting to order.

B. Attendance

Members Present: Hon. Mark Chaney, Dr. Shawn Clark, Ms. Amanda Clement, Mr. David Connell, Ms. Kay Daneault, Ms. Annette Giessner, Mr. Ronney Henderson, Ms. Jamie Himes, Ms. Sandy Kinnan, Ms. Toniya Lay, Ms. Tara Manning, Dr. Janette McCrory, Ms. Judy Newton, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Kim Richardson, Ms. Tonya Tate, Ms. Tameka Tobias, Dr. Scott Willoughby, Ms. Melody Worsham

Members Absent: Dr. Chelsea B. Crittle, Ms. Margaret Ellmer, Dr. Maxie Gordon, Ms. LaVonda Hart, Ms. Jessica James, Dr. Joe Kinnan, Ms. Harriette Mastin, Mr. Ben Mokry, Ms. Ekoko Onema, Ms. Wanda Thomas, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White, Mr. Mark Williamson

DMH Staff Present: Ms. Sherry Holloway, Mr. Brent Hurley, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Lynda Stewart, Ms. Carman Weaver

Guests Present: Ms. Linda Foley, Mr. Aaron Moore, Mr. Henry Moore, Maj. Jamie Tedford, Mr. Auvergne Williams

II. Approval of Minutes

It was moved by Hon. Mark Chaney and seconded by Ms. Tonya Tate that the May 2, 2019, minutes be approved as presented. The motion carried.

III. Old Business

None

IV. New Business

A. DMH Budget Update
Jake Hutchins – Mississippi Department of Mental Health
Bureau of Behavioral Health Services Director

The FY20 budget will be submitted to the Legislative Budget Office today. Mr. Breland will report on more specific areas of the budget request at the next meeting. The official Block Grant award information will be available at that time as well. Presently closing out FY19 and starting the new FY20 process.

B. FY2020–2021 MHBG Application/State Plan Update
Lynda Stewart – Mississippi Department of Mental Health
Division of Children and Youth Services

A draft of the FY2020-2021 MHBG Application/State Plan Update was sent to council members on July 23, 2019. There will be changes made to this version prior to and after the comment period, which is set for August 12-30, 2019. Council members will be sent notification and instructions of how to access the application on the DMH website. If a copy of the application needs to be mailed, contact Ms. Stewart at lynda.stewart@dmh.ms.gov. The question and answer format is directed by SAMHSA and they request that the state be as brief and concise as possible. The application contains 18 sections, 10 of which require a response. DMH completes the entire application every year to give SAMHSA as much information as possible. The submission deadline is September 3, 2019. Any comments or questions can be sent to Ms. Stewart.

C. CIT Expansion Efforts in South Mississippi
Linda Foley – Pine Belt Mental Health
Major Jamie Tedford – Jones County Sheriff's Department

The CIT (Crisis Intervention Team) program was first developed 1988 in Memphis, Tennessee. The CIT program is a community partnership between a law enforcement agency, a CMHC, a hospital, other mental health providers, consumers and family members of consumers. It is a police-based crisis intervention training to enable individuals with mental illness to access medical treatment and divert them from the judicial and criminal justice system. In 2018, SAMSHA awarded $1.8 million over a 5-year period through the Law Enforcement Diversion Grant. The first CIT training was done in 2016 in Jones County through the BJA Grant. Since then, there have been 17 trainings, 187 law enforcement officers have been certified, and the CIT program is active in all counties except 2 (in Pine Belt Mental Health's catchment area). Grant overall goals are to expand and improve sustainability. This year the focus has been to develop Pike and Harrison counties with a goal of training 24 officers. The goal was exceeded, 42 officers have been certified. A Train the Trainer is planned for October in Pike County to teach law enforcement and mental health providers how to perform CIT training. Major Sam Cochran, co-founder of CIT, and Dr. Tom Kirchberg will be facilitating. A social media marketer has been hired to promote CIT and other media outlets are being explored as well. This grant contains an added comparison of outcomes between CIT contacts who are and are not immediately engaged with MCERT (Mobile Crisis Response Team). Presentations will be made at the 2019 CIT International Conference on *Treatment Engagement and CIT* and *The Community Concept of Writing Grants*. Since 2016, there have been approximately 1,000 calls: 25% were safely de-escalated on the scene; 16% had medical problems; 53% were sent to the single point of entry; and 6% were arrested on a criminal charge. The

number of inmates with mental illness decreased from 60 a month to 5. A community-based group in Hattiesburg is working on a campaign to develop a diversion center. Approximately $2 million has been donated but more is needed to complete and sustain the project. Ms. Foley has applied for a grant.

There was discussion that CIT's often have difficulty securing a single point of entry in each area leaving multiple counties to use the same facility. It was noted that Peer Support Specialists could benefit jail holding areas by mitigating with mental health help or assisting with triage. Hospitals are often more receptive to local people and it is good to make contact through community connections to advocate for CIT. DMH added a CSU in every catchment area that didn't have one and all are operational, except Region 11. However, they have located a building in Natchez and DMH hopes to have a CSU up and going for that area by January 2020.

D. New/Additional Mental Health Services for Adults
Sherry Holloway and Brent Hurley –
Mississippi Department of Mental Health
Department of Community Services

To expand community-based services, funds were diverted from institutional budgets to the Service Budget. This enabled new and/or additional mental health services to be provided. New Crisis Stabilization Units (CSU) were opened across the state, including; Tupelo (October 2018), West Point (February 2019), Gautier (May 2019), Jackson (June 2019), Marks (July 2019), and Natchez (scheduled to open January 2020). Community Crisis Enhancement was provided for regions with existing CSU's (Regions 2, 4, 6, 8, 10, 12, 13, 15). Each region utilized their funds to meet the needs of their specific area (e.g. hiring specialized staff, adding PACT Team). As part of Community Crisis Enhancement, I-CORT (Intensive Community Outreach and Recovery Team) was added to each region that did not have a PACT Team. The pilot site was opened March 1, 2019 in Region 2 and teams are now operational in Regions 1, 7, 11, 14. A new PACT Team was opened in Region 8 in November 2018. For regions that did not have Supported Employment, Supported Employment Expansion was designed through a collaboration between DMH and MDRS. Vocational Rehab staff will work with the CMHC's to provide these services to individuals who are interested in employment in Regions 3, 4, 8, 9, 11, 14.

E. Announcements

(1) Rally for Recovery
September 14, 2019 • Ocean Springs, MS

(2) NAMI Walks Vicksburg
September 28, 2019 • Pemberton Mall

(3) NAMI Walks Mississippi
October 5, 2019 • LeFleur's Bluff State Park Jackson, MS

(4) NAMI Walks Hattiesburg
October 26, 2019 • Kamper Park

H. Other Public Comments

(1) Staff turnover among professional staff was discussed and it was noted that offering scholarships could be an incentive. DMH doesn't offer scholarships but has been exploring new ideas to help with this issue. Dr. McCrory has nursing graduate data, or it can be found on the website at www.ihl.state.ms.us.

(2) NAMI Walks raise money for community projects and programs. NAMI Walk Hattiesburg provides community support for programs such as MHFA and YMHFA trainings and the CIT Recognition Program. Come out and participate in NAMI Walks and advocate for NAMI MS.

(3) If anyone has a need for Public Safety MHFA training in their community, contact Brent Hurley at brent.hurley@dmh.ms.gov.

(4) There was concern regarding 5% assessment fees (retroactive to July 2018) being requested by the managed care companies from the CMHC's. A managed care work group/task force met during the last legislative session, however, no changes were made. This is an ongoing disputes between managed care and CMHC's.

(5) Awaiting ruling from presiding judge regarding DOJ trial. Briefs are available online.

(6) Region 13 notified DMH that they would be closing on August 11, 2019. Financial complications arose due to credentialing issues. The Board of Mental Health authorized DMH to work with the counties to reconcile the problems. DMH has an agreement in place with the counties and no services have stopped. The counties maintain their efforts to alleviate the situation and DMH hopes to have services continue as usual.

V. Next Meeting/Topics

A. Topic Recommendations

None

B. Next Meeting

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, November 7, 2019, at 10:00 a.m.

VI. Adjournment

The meeting was adjourned at 11:53 a.m.

Mississippi State Mental Health
Planning and Advisory Council Meeting

AGENDA

Thursday, November 8, 2018

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (August 9, 2018)

3. Old Business

4. New Business

   A. DMH Budget Update
      Kelly Breland – Mississippi Department of Mental Health
      Bureau of Administration Director

   B. State Plan Implementation Report Update
      Sandra Parks – Mississippi Department of Mental Health
      Children and Youth Services Division Director

   C. CIT Expansion Grant
      Brent Hurley – Mississippi Department of Mental Health
      Adult Services Division Director

   D. Hattiesburg Behavioral Health Court
      Khadijah Muhammad – Hattiesburg Community Initiatives and Behavioral Health Court Coordinator
      Judge Wes Curry – City of Hattiesburg Municipal Court

   E. New Employment Grants/PACT Teams
      Jake Hutchins – Mississippi Department of Mental Health
      Community Services Bureau Director

   F. Announcements

   G. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
November 8, 2018
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chairperson

A. Opening

Council Chairperson, Mr. Connell, called the meeting to order.

B. Attendance

Members Present/Represented: Ms. Rachel Chandler, Hon. Mark Chaney, Ms. Amanda Clement, Mr. David Connell, Ms. Annette Giessner, Mr. Ronney Henderson, Ms. Jessica James, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Tara Manning, Ms. Ekoko Onema, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Kim Richardson, Ms. Tonya Tate, Ms. Tameka Tobias, Mr. Larry Waller, Ms. Nancy White, Dr. Scott Willoughby

Members Absent: Dr. Shawn Clark, Dr. Chelsea B. Crittle, Ms. Kay Daneault, Ms. Margaret Ellmer, Dr. Maxie Gordon, Ms. LaVonda Hart, Ms. Jamie Himes, Ms. Toniya Lay, Mr. Mark Leiker, Dr. Janette McCrory, Mr. Ben Mokry, Ms. Rilecia Swayze, Mr. Harold White, Ms. Melody Worsham

DMH Staff Present: Ms. Aurora Baugh, Mr. Kelly Breland, Mr. Joey Craft, Mr. Brent Hurley, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Carman Weaver

Guests: Hon. Wes Curry, Mr. George Green, Ms. Khadijah Muhammad, Ms. Stephanie Williams, and Ms. Kenyada Washington representing Mr. Mark Williamson

II. Approval of Minutes

It was moved by Ms. Tonya Tate and seconded by Ms. Amanda Clement that the August 8, 2018, minutes be approved as presented. The motion was carried.

III. Old Business

None

IV. New Business

A. DMH Budget Update
Kelly Breland – Mississippi Department of Mental Health
Bureau of Administration Director

DMH presented the FY20 Budget Request in the amount of $582,991,672 to the Legislative Budget Committee at their meeting September 21, 2018. DMH is requesting level funding for state source funds except for employers required contribution to the Public Employees'

Retirement System which will be $1,824,931. The FY20 DMH Budget Request expenditures and budget to be funded were reviewed, as well as the FY19 shifted funds from the institutional budgets to the Service Budget.

B. State Plan Implementation Report Update
Sandra Parks – Mississippi Department of Mental Health
Children and Youth Services Division Director

Information is being gathered for the FY18 State Plan Implementation Report that is due December 1, 2018. Mississippi State University, who was contracted to carry out the survey process, sent the surveys out about a month ago and are expecting a good return. Random surveys from the CDR were sent out anonymously via several means and another blast will be sent in the spring of 2019. Ms. Lynda Stewart will be keying in data and numbers before Thanksgiving. Once the Implementation Report is complete and submitted through SAMHSA's electronic application system, WebBGAS, it will be emailed to council members and posted on the DMH website.

C. CIT Expansion Grant
Brent Hurley – Mississippi Department of Mental Health
Adult Services Division Director

CIT (Crisis Intervention Team) is a law enforcement jail diversion program for people with mental illness in crisis and DMH has made training available in hopes of implementing CIT in communities across the state. Ms. Linda Foley at Pine Belt Mental Healthcare was pivotal in applying for and receiving the CIT Expansion Grant awarded in September of this year for $1.65 million (to be divided over 5 years). The grant will begin September 30, 2018. Pine Belt Mental Healthcare has a great CIT Training Team and DMH plans to contract with them to begin CIT training in counties that are interested in the southern part of the state (I-20 and south). Ms. Foley also wrote a CIT Starter Toolkit Book to share with interested communities. Harrison County is already getting started and Adams, Warren, Pike and Lincoln counties are interested. North of I-20, there is interest in Oxford, Water Valley and Tupelo, where a new CSU was just opened. DMH still has the Expansion Grant with the East Mississippi CIT Program in Lauderdale County, where officers attend their location to experience CIT training. The coordinator there is focusing on the north part of the state. Hinds County has had 3 trainings. St. Dominic's Hospital and Merit Health Center serve as their single point of entry.

D. Hattiesburg Behavioral Health Court
Khadijah Muhammad – Hattiesburg Community Initiatives and Behavioral Health Court Coordinator
Judge Wes Curry – City of Hattiesburg Municipal Court

Behavioral Health Court is a jail diversion program for individuals with SMI (Serious Mental Illness) facing misdemeanor charges. These misdemeanor charges range from domestic abuse, disorderly conduct, simple assault, to other violent crimes. This is a situation brought about by a person struggling with SMI, who would otherwise have no criminal inclination, but has now set in motion a course with law enforcement and the courts. Hattiesburg Behavioral Court is the only behavioral court in Mississippi and was started in 2009 under a grant from

the DOJ lasting 2 years. After a shake up in the courts, the grant was lost but a new grant was awarded in 2014. Judge Wes Curry was appointed by Mayor Toby Barker in October 2017, but the program had not been utilized to its full potential. Ms. Khadijah Muhammad joined Judge Curry in January of this year and they began to mend bridges between NAMI Pine Belt, Pine Belt Mental Healthcare and the courts. The program is strictly voluntary. The participant pleads guilty and the court holds the guilty plea until the following steps are completed: 1) the court connects the person with Pine Belt Mental Healthcare for stabilization and needed treatment; 2) support is made available to the person for needed life skills; 3) the person is assisted in completion of any required classes associated with their charges. This program can only be successful with the continued support of community partners. Rep. Becky Currie introduced a bill to the Legislature last year to create Behavioral Health Courts statewide at the felony level, however the bill died in committee in the Senate. Behavioral Health Courts are important to communities and people are beginning to see the need for them.

E. New Employment Grants/PACT Teams
Jake Hutchins – Mississippi Department of Mental Health
Community Services Bureau Director

DMH awarded an additional NAVIGATE Program and PACT Team with the Block Grant increase. NAVIGATE Programs were funded in Region 15, Region 9 and Region 8, totaling 5 first episode psychosis programs for young adults. The additional PACT Team was funded in Region 8 making a total of 10 PACT Teams in the state. DMH offered Employment Specialist positions to the 10 CMHCs, with 4 already having employment grants. Vocational Rehabilitation will be securing the jobs and the Employment Specialists will be following the individuals that want to work to Vocational Rehabilitation.

The $8 million that was shifted July 1st to the community funded the following CSU (Crisis Stabilization Unit) openings – Region 3 opened a 4-bed CSU on October 17, 2018, which will probably be expanded to a 8-bed unit in the near future, Region 7, will open the next CSU with 8-beds, Region 9 will soon open an 8-bed CSU and shortly thereafter lease another building to have a 16-bed unit, Region 11 will open a CSU, and Region 14 is opening an 8-bed CSU in January. Region 15 has a partnership with a CSU and a holding facility that is certified through DMH. Some regions requested specific funding. Region 4 requested funding for another PACT Team for their other 4 counties. Region 12 requested CSU funding for staff and security to work more efficiently with challenging individuals. The remaining regions requested Intensive Case Managers for each of their counties and Court Liaisons to work with those filing commitments. The Peer Bridger program at North Mississippi State Hospital is currently “refocusing” and DMH hopes to expand the program to other areas.

F. Announcements

New employees at DMH, Division of Community Services, are Ekoko Onema, Joey Craft and Natalie Blackmon (not present). Also new council member, Ms. Jessica James, HBHS CPSS.

G. Other Public Comments

NAMI Walks is a very important aspect in raising funds for NAMI in their effort to provide community educational programs, support groups, awareness projects, presentations, as well as fighting stigma in Mississippi. This year Mississippi was allowed to divide the walks into different areas of the state. NAMI Walks Pine Belt was held October 27th and raised $12,000. The City of Hattiesburg became a patron member of NAMI and Mayor Toby Barker issued a proclamation which will be displayed at the Hattiesburg Behavioral Health Court.

NAMI Mississippi turns "30" next year. To celebrate, a gala will be held on the first night of the NAMI Conference which will be May 16–18, 2019, at Belhaven College. If anyone is interested in serving on the planning committee, contact Ms. Tameka Tobias.

V. Scheduling of Next Meeting/Topics

Suggested topics for upcoming meetings:

- Bill Rosamond DOJ Update

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, February 7, 2019 at 10:00 a.m. The quarterly meeting dates for 2019 will be May 2nd, August 1st, and November 7th.

VI. Adjournment

The meeting was adjourned at 11:36 a.m.

Mississippi State Mental Health
Planning and Advisory Council Meeting

AGENDA

Thursday, February 7, 2019

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (November 8, 2018)

3. Old Business

   A. Election of New Officers

4. New Business

   A. DMH Budget Update
      Kelly Breland – Mississippi Department of Mental Health
      Bureau of Administration Director

   B. State Plan Implementation Report Update
      Lynda Stewart – Mississippi Department of Mental Health
      Division of Children and Youth Services

   C. DOJ Update
      Bill Rosamond – Office of Attorney General, State of Mississippi
      Special Assistant Attorney General

   D. Mississippi Integrated Care Project
      Dr. Tiffany T. Anderson – Hinds Behavioral Health Services
      Deputy Director/Grants Manager

   E. Announcements

   F. Other Public Comments

5. Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
February 7, 2019
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chair

A. Opening

Council Chair, Mr. Connell, called the meeting to order.

B. Attendance

Members Present: Ms. Rachel Chandler, Hon. Mark Chaney, Dr. Shawn Clark, Ms. Amanda Clement, Mr. David Connell, Dr. Chelsea B. Crittle, Ms. Annette Giessner, Ms. LaVonda Hart, Mr. Ronney Henderson, Ms. Jamie Himes, Ms. Jessica James, Dr. Joe Kinnan, Ms. Sandy Kinnan, Ms. Toniya Lay, Ms. Tara Manning, Ms. Harriette Mastin, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Kim Richardson, Ms. Tonya Tate, Ms. Tameka Tobias, Mr. Harold White, Dr. Scott Willoughby

Members Absent: Ms. Kay Daneault, Ms. Margaret Ellmer, Dr. Maxie Gordon, Dr. Janette McCrory, Mr. Ben Mokry, Ms. Ekoko Onema, Ms. Rilecia Swayze, Mr. Larry Waller, Ms. Nancy White, Mr. Mark Williamson, Ms. Melody Worsham

DMH Staff Present: Ms. Wendy Bailey, Ms. Aurora Baugh, Ms. Natalie Blackmon, Mr. Kelly Breland, Ms. Sherry Holloway, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Carman Weaver

Guests Present: Dr. Tiffany T. Anderson, Mr. Wayne Mastin, Mr. Bill Rosamond

II. Approval of Minutes

It was moved by Hon. Mark Chaney and seconded by Ms. Sandy Kinnan that the November 8, 2018, minutes be approved as presented. The motion carried.

III. Old Business

None

IV. New Business

A. Election of New Officers
David Connell – Chair

Mr. Connell established a Nominating Committee for new officers. The members are Ms. Tameka Tobias, Dr. Joe Kinnan, Ms. Tonya Tate, and Dr. Scott Willoughby. This committee will bring nominations for election of officers to the next council meeting on May 2, 2019. Current officers are: Mr. David Connell, Chair; Ms. Amanda Clement, Vice-Chair; Ms. Sandy Kinnan, Secretary; and Ms. Annette Giessner, Parliamentarian. Dr. Kinnan asked if anyone has suggestions for officers, they contact someone on the Nominating Committee and that the committee assemble immediately after today's meeting.

B. DMH Budget Update
Kelly Breland – Mississippi Department of Mental Health
Bureau of Administration Director

The DMH FY20 Budget Request presentation to the House and Senate Appropriations Subcommittees contained a general overview with a focus on budget highlights. These highlights included the progress with FY19 level state source funding, the funding shift to the community (including data on Mobile Crisis Response Teams, PACT Teams, and new enrollment to ID/DD Waiver), moving towards a Community-Based System of Care, Direct Care Series realignment, and Forensic Services. The DMH Budget Request for FY20 totaled $589,267,157. DMH anticipates the need for an increase in General Funds for the FY21 Budget to continue expansion of Home and Community Based Waiver Services.

C. State Plan Implementation Report Update
Sandra Parks – Mississippi Department of Mental Health
Children and Youth Services Division Director

The FY18 State Plan Implementation Report was submitted to SAMHSA November 29, 2018. It was sent to council members on January 11, 2019. The data covers a period from July 1, 2017 – June 30, 2018. This report contains data outcomes submitted to SAMHSA to account for the use of the Block Grant. To organize and improve data collection, the DMH State Plan and Strategic Plan were aligned so the objectives and activities would be parallel.

D. DOJ Update
Bill Rosamond – Office of Attorney General, State of Mississippi
Special Assistant Attorney General

Mr. Rosamond gave an update on the status of the suit filed in August 2017, by the DOJ (Department of Justice) against the state of Mississippi. The trial date is set for June 4, 2019, and will be held at the United States Courthouse at 501 Court Street in Jackson. The state currently has two motions for summary judgement pending with the court that have not been set for hearing. If the motions are denied, the state of Mississippi will go to trial on the case.

E. Mississippi Integrated Care Project/CSU Update
Dr. Tiffany T. Anderson – Hinds Behavioral Health Services
Deputy Director/Grants Manager

Hinds Behavioral Health Services (HBHS) and Pine Belt Healthcare Resources (PBMH) have been awarded a four-year, $1.9 million Integrated Healthcare Project Grant. This integrated system will offer primary care and behavioral health at one site. HBHS is partnering with Central Mississippi Health Services and PBMH is partnering with Southeast Mississippi Rural Health Initiative. HBHS is slated to begin services in May.

One of the HBHS CSU facilities has been remodeled and will accommodate 12-beds. The board has approved and signed a lease agreement for the second building with remodeling to begin at the end of the month (together will be a 16-bed CSU). The 12-bed facility is almost ready; furniture has been ordered and staff is being hired. It has been difficult to find nursing and direct care staff for challenging shifts (2nd, 3rd, weekends). It is in the final stages of completion and will be ready to open very soon.

F. Legislative Update
Wendy Bailey – Mississippi Department of Mental Health
Chief of Staff

Members were given a handout and Ms. Bailey reviewed bills that DMH is tracking in the legislature. Contact her for further information if needed.

Council members will receive a survey on Monday regarding a mental health resources website to be maintained by DMH. Ms. Bailey asked that everyone be thinking of information that would be beneficial to the site and suggestions to make it user friendly.

DMH is starting a partnership with the MS Department of Health on the link between chronic disease (e.g. diabetes, heart disease) and mental health. DMH is preparing resource material to be shared upon admission to a state hospital. It will be a booklet with information that can be worked through, including social media pieces, and the information can be taken with the person upon discharge or visit to the CMHC. DMH would like to share this via email with the council for feedback in developing the material.

G. Announcements

(1) Mental Health Day at the Capitol 8:00am-10:30am
NAMI Handout • Speakers & Vendors

(2) *NAMI Mississippi Turns 30 Gala*
May 16, 2019 • Belhaven University

(3) 2019 NAMI Mississippi State Conference
May 16-17, 2019 • Belhaven University

(4) NAMI Pine Belt Signature Program Leader Training: Offering NAMI Connection Recovery Support Group and NAMI Family Support Group
March 16-17, 2019 • Forrest General Hospital in Hattiesburg

(5) NAMI Pine Belt Signature Program Leader Training: Offering NAMI Family-to-Family and NAMI Peer-to-Peer
March 23-24, 2019 • Forrest General Hospital in Hattiesburg

H. Other Public Comments

(1) Dr. Kinnan commended NAMI MS on the tremendous job it does. He shared the Stigma-free plaque that will be presented to the Mayor of Hattiesburg as a sponsoring city. Dr. Kinnan thanked Ms. Tobias for her leadership.

(2) Ms. Tobias stated that NAMI MS has partnered with affiliates across the state to hold trainings in their area.

V. Next Meeting

A. Topic Recommendations

None

B. Next Meeting

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, May 2, 2019, at 10:00 a.m.

VI. Adjournment

The meeting was adjourned at 11:33 a.m.

Mississippi State Mental Health
Planning and Advisory Council Meeting

Thursday, May 2, 2019

1. Call to Order – **David Connell** – Chair

2. Approval of Minutes (February 7, 2019)

3. Old Business

   A. Election of New Officers

4. New Business

   A. DMH Budget Update
      Jake Hutchins – Mississippi Department of Mental Health
      Bureau of Behavioral Health Services Director

   B. FY 2020–2021 MHBG Application/State Plan Update
      Lynda Stewart – Mississippi Department of Mental Health
      Division of Children and Youth Services

   C. Shatter the Silence
      Ann Rodio – Mississippi Department of Mental Health
      Suicide Prevention Director

   D. Mental Health Awareness Training Grant
      Molly Portera – Mississippi Department of Mental Health
      Division of Outreach and Training Director

   E. Competency Education
      Emile Craig – Region 8 Mental Health Services
      Chief Operations Officer

   F. Announcements

   G. Other Public Comments

5. Scheduling of Next Meeting/Topics

6. Adjournment

Mississippi State Mental Health Planning and Advisory Council
Minutes of Quarterly Meeting
May 2, 2019
Mississippi State Hospital, Building 56 Conference Room

I. Call to Order – David Connell, Chair

A. Opening

Council Chair, Mr. Connell, called the meeting to order.

B. Attendance

Members Present: Hon. Mark Chaney, Ms. Amanda Clement, Mr. David Connell, Ms. Kay Daneault, Ms. Annette Giessner, Ms. Jessica James, Dr. Joe Kinnan, Ms. Tara Manning, Mr. Ben Mokry, Ms. Judy Newton, Ms. Elaine Owens, Ms. Coreaner Price, Ms. Kim Richardson, Ms. Wanda Thomas, Ms. Tameka Tobias, Mr. Larry Waller, Mr. Harold White, Ms. Nancy White, Ms. Melody Worsham

Members Absent: Dr. Shawn Clark, Dr. Chelsea B. Crittle, Ms. Margaret Ellmer, Dr. Maxie Gordon, Ms. LaVonda Hart, Mr. Ronney Henderson, Ms. Jamie Himes, Ms. Sandy Kinnan, Ms. Toniya Lay, Ms. Harriette Mastin, Dr. Janette McCrory, Ms. Ekoko Onema, Ms. Tonya Tate, Mr. Mark Williamson, Dr. Scott Willoughby

DMH Staff Present: Ms. Natalie Blackmon, Mr. Kelly Breland, Mr. Jake Hutchins, Ms. Sandra Parks, Ms. Lynda Stewart, Ms. Carman Weaver

Guests Present: Ms. Brooke Rice, Mr. Theron Jenkins, Ms. Molly Portera, Ms. Courtney Littleton, Ms. Ann Rodio

II. Approval of Minutes

It was moved by Hon. Mark Chaney and seconded by Dr. Joe Kinnan that the February 7, 2019, minutes be approved as presented. The motion carried.

III. Old Business

A. Election of New Officers
David Connell – Chair

The Nominating Committee established at the last meeting put forth their nominees for the new term of officers. A motion was made by Ms. Annette Giessner to re-elect Mr. David Connell as Chair, a second was made by Ms. Amanda Clement, and the motion carried. A motion was made by Ms. Nancy White to re-elect Ms. Amanda Clement as Vice-Chair, a second was made by Dr. Joe Kinnan, and the motion carried. A motion was made by Ms. Melody Worsham to re-elect Ms. Sandy Kinnan as Secretary, a second was made by Ms. Annette Giessner, and the motion carried. A motion was

made by Dr. Joe Kinnan to re-elect Ms. Annette Giessner as the Parliamentarian, a second was made by Hon. Mark Chaney, and the motion carried. The new slate of officers is as follows: Chair, Mr. David Connell; Vice-Chair, Ms. Amanda Clement; Secretary, Ms. Sandy Kinnan; Parliamentarian, Ms. Annette Giessner.

IV. New Business

A. DMH Budget Update
Kelly Breland – Mississippi Department of Mental Health
Bureau of Administration Director

The DMH's appropriation's bill, SB 3027, included $213,668,778 in general funds, $367,303,571 in special funds, and $18,951,886 in health care funds. This includes funding for the PERS employer contribution increase, $1 million to expand mental health community-based services, a little more than $1.2 million to increase ID/DD Home and Community Based Waiver slots by approximately 120, and to provide full-time state employees with an up to 3% pay increase to the realignment component of the Variable Compensation Plan (excluding head of agencies, board members and commission members).

Dr. Sandy Rogers, Region 2, is piloting the first Intensive Community Outreach and Recovery Team (ICORT), which is a service similar to PACT Team. Staffing consists of a registered nurse, a masters level staff, a bachelors level staff, and a peer support specialist. With the $1 million Governor Bryant secured for DMH community mental health services, DMH hopes to start four more ICORT programs in an effort to have some level of intensive PACT type service in every CMHC region of the state. The areas will include Region 1 (Clarksdale), Region 7 (Starkville), Region 11 (McComb), and Region 14 (Gautier).

B. FY2020–2021 MHBG Application/State Plan Update
Lynda Stewart – Mississippi Department of Mental Health
Division of Children and Youth Services

The guidance was just posted on the SAMHSA website and approved by the Office of Management and Budget. The guidance is in question and answer format, the same as previous years. It must be submitted by September 3, 2019. The DMH FY2020-2021 MHBG Application and State Plan aligns directly with the DMH Strategic Plan. Council members will be given a rough draft before the next meeting on August 1, 2019. Any questions or comments can be sent to Ms. Lynda Stewart via email at lynda.stewart@dmh.ms.gov or can be done at the August meeting.

C. Shatter the Silence
Ann Rodio – Mississippi Department of Mental Health
Suicide Prevention Director

Shatter the Silence is a prevention program that was started with a SAMHSA grant in 2008 and has been maintained through DMH funding. This has been a successful and valuable initiative responsible for training over 10,000 youth serving agency staff on

suicide prevention in 2018. Presentations are available that are tailored to youth, adults, older adults, faith-based youth, faith-based adults, Mississippi Highway Patrol, law enforcement and first responders, correctional officers, and National Guard. A presentation can be customized for any population. DMH is teaming with DPS, the Bureau of Narcotics, and the Bureau of Investigation to develop training for officers. Pinelake Church will be the pilot site for faith-based training. This weekend the National Guard has seven yellow ribbon events planned. A Shatter the Silence phone app will be available in May and a Train the Trainer event is scheduled in August.

Also, a major awareness campaign will be kicked off in August encouraging gun owners to practice responsible gun safety. This is due to the large number of suicides resulting from firearms. A press release and media event are planned.

D. Mental Health Awareness Training Grant (MHAT)
Molly Portera – Mississippi Department of Mental Health
Division of Outreach and Training Director

The Mental Health Awareness Training Grant was awarded to DMH as a 3-year grant to begin September 30, 2018. The focus is to provide Youth Mental Health First Aid (YMHFA) training to educators, school resource officers, parents, and caregivers. Over the course of the grant, DMH hopes to train 1,800 educators, 450 school resource officers, and offer regional parent/caregiver training. Additionally, a mental health resource website is being developed and should be finished by the end of the year. DMH hosted an instructor training in February 2019 and will partner with those instructors and others to help provide trainings across the state. Ms. Courtney Littleton, MHAT Grant Coordinator, has completed 6 trainings and there are 27 confirmed trainings scheduled for this year. DMH has partnered with several CMHC's to use their YMHFA instructors and this summer there are 18 trainings planned and 11 of them are in the CMHC's. DMH will host 6 trainings over 3 days at the Mississippi Association of School Resource Officers Conference in June. If there is an organization or community group that would benefit from this training, contact Ms. Molly Portera or Ms. Courtney Littleton at molly.portera@dmh.ms.gov or courtney.littleton@dmh.ms.gov.

E. Competency Education
Brooke Rice – Region 8 Mental Health Services
Competency Education Program Coordinator
Theron Jenkins – Region 8 Mental Health Services
Competency Education

In 2017, Mississippi State Hospital and Region 8 Mental Health Services worked together to implement a jail-based competency restoration program serving Hinds, Holmes, and Madison counties. The program was expanded to Region 13, Gulf Coast Mental Health Center, in 2018, serving Forrest, Hancock, Pearl River, Jackson, Harrison, and Stone counties. The Competency Education Program provides defendants with individual and group services, anger management and anxiety reduction, education and support. Competency evaluators are trained by Forensic Services staff to collect the information to be provided for the Forensic Services Team, who make the decision regarding the defendant's competence. The MSH Forensic

Services unit is the only state-operated program that provides forensic mental health services for circuit courts in all 82 counties and currently has 15 beds with plans to expand to a 60-bed building.

G. Announcements

(1) Consumer Rights Committee
Meeting today at 12:30 p.m.

(2) *NAMI Mississippi Turns 30 Gala*
May 16, 2019 • Belhaven University

(3) 2019 NAMI Mississippi State Conference
May 16-17, 2019 • Belhaven University

(4) Open Up Mississippi Youth Initiative Press Release
May 18, 2019 • Belhaven University

(5) Annual AMPSS Peer Summit
May 30-June 1, 2019 • Jackson Marriott

(6) Families as Allies Leadership Training for Parent/Caregiver Leaders
June 2019 (specific date TBD) • for more information
call Families as Allies at 601-355-0915 or 800-833-9671

H. Other Public Comments

(1) Ms. Owens recommended a book for the council to read, *Insane Consequences: How the Mental Health Industry Fails the Mentally Ill*.

(2) Mr. Mokry gave an update on the CHOICE program. Due to the success of the program, the legislature has continued funding each year. For FY20, the legislature appropriated an additional $1.4 million to the DFA budget for CHOICE. DFA is the fiscal agent for the program.

(3) Mr. Hutchins gave an update on the programs funded by the $8 million shift to the community for the expansion of services.

- Region 1 (Region 1 Mental Health Center) will open a Crisis Stabilization Unit in Marks, Mississippi pending the delivery and assembly of 2 doors.
- Region 3 (LIFECORE Health Group) opened a 4-bed Crisis Stabilization Unit in October 2018.
- Region 7 (Community Counseling Services) opened an 8-bed Crisis Stabilization Unit in December 2018.
- Region 9 (Hinds Behavioral Health Services) held an Open House for their 16-bed Crisis Stabilization Unit on April 29, 2019. The unit started receiving individuals Wednesday, May 1, 2019.
- Region 11 (Southwest Mississippi Mental Health Complex) continues in their effort to locate a building.

- Region 14 (Singing River Services) opened an 8-bed Crisis Stabilization Unit in February 2019.
- ICORT Teams – (see A. Budget Update)
- Supported Employment has been successfully established in Regions 2, 7, 10, and 12. New sites have been started in Regions 3, 4, 8, 9, 11, 14, and 15. DMH has a close working relationship with Vocational Rehabilitation.
- The Mental Health Association of South Mississippi started the Opal Smith Drop-In Center in Gulfport. When visited in 2017, the staff administering the federal site visit were very pleased.
- Hinds Behavioral Health Services has opened The BRIDGE Drop-In Center in Jackson across from Poindexter Park. It has been extremely successful.
- There are plans for another drop-in center in Forrest County through Pine Belt Mental Healthcare Resources. The mayor is assisting them in locating a building.

(4) Mr. Connell reminded council members to contact their representatives. As a large group, it would make a great representation for mental health.

Mr. Chaney reiterated that this is election year and voters should let candidates know you are interested in mental health. It doesn't matter what party they represent, it's about the people they want to serve.

V. Next Meeting/Topics

A. Topic Recommendations

None

B. Next Meeting

The next Mississippi State Mental Health Planning and Advisory Council meeting will be held Thursday, August 1, 2019, at 10:00 a.m.

VI. Adjournment

The meeting was adjourned at 12:04 p.m.

Meeting Minutes

Assembly:	**MS Department of Mental Health, Bureau of Behavioral Health/Addictive Services Advisory Council**
Today's Date:	**Thursday, October 10, 2019**
Location:	MS Department of Mental Health 1101 Robert E. Lee Building 239 N. Lamar Street Jackson, MS 39201 12th Floor, Conference Room-C 601-359-6671 or 601-359-6220
Date Minutes are From:	**Thursday, July 11, 2019**
Meeting Time:	1:30 p.m. - 3:03 p.m.

Member Attendance:

	Name of Member	Agency	Present	Excused	Absent	Proxy
(1)	Bean, Dewitt	Retired			X	
(2)	Bland, "Bubba" William	Attorney General Office			X	
(3)	Bufkin, Greg	El Roi Ministries	X			
(4)	Chaney, Mark	Retired	X			
(5)	Clark, Shawn Dr. **(Vice-Chairperson)**	VA Medical Center	X			
(6)	Cobb, Terry	Pastor/ Deputy Sheriff Sunflower County			X	
(7)	Dean, Tamritha	MS Office of Disability Determination Services	X			

Meeting Minutes

Member Attendance:

	Name of Member	Agency	Present	Excused	Absent	Proxy
(8)	De la Pena, Dr. Nelson Atehortua MD, PhD, MPH	JSU-School of Public Health Global Health Initiative		X		
(9)	Elrod, Carol	Vocational Rehabilitation	X		X	
(10)	Evans, Lit	Retired/ Superintendent of Education	X			
(11)	Freeman, Dr. Kevin	UMMC Psychiatry/Human Behavior		X		
(12)	Grist, Joe **(Chairperson)**	North MS State Hospital	X			
(13)	Henderson, Ronney	VA Medical Center	X			
(14)	Holmes, Pamela S.	Supreme Court of Mississippi	X			
(15)	Johnson, Martha Lynn	South Panola Community Coalition	X			
(16)	LeSure, Kennan B.	Hanging Moss Road Church of Christ/Retired, Board of Pharmacy	X			

Member Attendance:

	Name of Member	Agency	Present	Excused	Absent	Proxy
(17)	Mallette, Angela	LEAD Mississippi			X	
(18)	Matens, Paul	VA/Retired	X			
(19)	McAfee, Bettye	Choctaw Behavioral Health	X			Jody Dorman, Therapist
(20)	McCoy, Susan	MS Board of Pharmacy	X			
(21)	Miley, Charlotte	MS State Hospital, LSW/Retired			X	
(22)	Moffett, Sandra	Retired/Dept. of Public Safety	X			
(23)	Moore, James	Behavioral Health Advocate	X			
(24)	Oliver, Curtis	Recovery Advocacy (FAVOR)	X			
(25)	Onema, Ekoko	DMH		X		
(26)	Owens, Dwight	Motivational Speaker/ American with Disabilities Act Consultant	X			
(27)	Powell, Julie	Brentwood Behavioral Health	X			
(28)	Ross, Dr. Mary Ann	MS Department of Corrections	X			

Meeting Minutes

Member Attendance:

	Name of Member	Agency	Present	Excused	Absent	Proxy
(29)	Session, Terry James	Millcreek of Pontotoc	X			
(30)	Shine, Angela L.	CEO Radical Inc.		X		
(31)	Tureaud, DeGarrette	MS Dept. of Health, Office of Tobacco Control	X			
(32)	Wisdom, Dawn	American Addiction Centers	X			

Bureau of Behavioral Health/ Addictive Services Staff:

	Name of Staff	Present	Name	Present
(1)	Bell, Felita	X	(7) Smith, Kathy	X
(2)	Bell, Misty		(8) Smith, Pamela	X
(3)	Ewing, Dr. E. Elaine	X	(9) Trewolla, David	X
(4)	Hutchins, Jake	X	(10) White, Belen	
(5)	Michael, Dr. Latarsha	X	(11) Wilson, Eric	X
(6)	Oliphant, Chuck	X		

Guest Speaker:

Name of Speaker	Agency
Mr. Mark Chaney Behavioral Health Community Advocate	Bureau of Behavioral Health/Addictive Services Advisory Council MS Department of Mental Health

Meeting Minutes

		1101 Robert E. Lee Building 239 N. Lamar Street Jackson, MS 39201
	Name of Speaker	**Agency**
Guest Speakers:	Ms. Sha'Ketta Davis	Delta Health Alliance 435 Stoneville Road Leland, MS 38756 Phone: 662.686.3905 sdavis@deltahealthalliance.org
	Ms. Brooks Ann Gaston	bagaston@deltahealthalliance.org
Guest Speakers:	Mr. Greg Bufkin	El Roi Ministries revzooftig@att.net
	Mr. Dwight Owens	*"Still Standing"* Motivational Speaker Author Disability-ADA Advocate/Consultant Alcohol/Substance Abuse Prevention

Meeting Minutes

	Name of Guest	Agency
Visiting Guest:	Ms. Ishauma Gully	601-498-2332 www.StillStandingWithDwight.com OwensDwight@yahoo.com Take A Stand, NO MORE 971 Poplar Drive Laurel, MS 39440 igully@yahoo.com 601-470-3788

	Agenda Topics	Agenda Notes
(1)	**Called To Order:**	The Chairperson, Mr. Joe Grist, called the meeting to order exactly at 1:30.
(2)	**Opening Prayer:**	Mr. Lit Evans gave a fervent and uplifting prayer that warmed the hearts of many in attendance. Mr. Evans contented, Behavioral Health is a profession that steams from genuine care and service. He reminded the council that we must treat everyone the way we want to be treated. We have accomplished nothing without His grace and mercy! Mr. Evans concluded, the Lord has a kind heart and we must replicate His likeness.
(3)	**Welcome/Opening Remarks:**	Mr. Joe Grist, MS Department of Mental Health, Bureau of Behavioral Health/Addictive Services Advisory Council, chairperson enthusiastically welcomed everyone to the meeting. Mr. Jake Hutchins, Bureau Director of Behavioral Health, greeted the council members and guest. However, due to unforeseen circumstances Mr. Hutchins had to leave the meeting for a prior

		appointment. He asked the council to please excuse his absence. Mr. Grist asked everyone to please come together in a moment of silence to reflect on those affected, still suffering and deceased from a substance use disorder. Afterwards, he asked the council if anyone had remarks before the opening presentation; there were none.
(4)	**Date of Previous Council Minutes:**	Approval of Meeting Minutes From: Thursday, July 11, 2019.
	Agenda Topics	**Agenda Notes**
(5)	**Approval of Council Minutes:**	Mr. Joe Grist made a motion to accept the council minutes as printed. Mr. Mark Chaney, Mr. Lit Evans and Mr. Curtis Oliver second the motion, there were no objections, the motion was carried, and the minutes were accepted as printed.
(6)	**I didn't know we had that in MS:**	• Mr. Mark Chaney, Behavioral Health Community Advocate, passionately said to the council, if you or someone you care about has a substance use disorder, there are services available. The MS Department of Mental Health, Bureau of Behavioral Health/Addictive Services offers a variety of services and programs to help people with a substance use disorder, they are prevention, outpatient and residential treatment. All of the services are responsive to community needs. To find additional information, Mr. Chaney encouraged everyone to: 1. Go to the DMH website: dmh.ms.gov 2. Call the DMH Helpline at 1-877-210-8513. Staff are available to provide help 24 hours a day.
(7)		• Ms. Brooks Ann Gaston, Assistant Vice President of Operations, Delta Health Alliance presented an overview of the following: Delta Health Alliance (DHA) Grants assist several counties (Desoto, Benton, Tunica, Tate, Tippah, Union, Panola, Coahoma, Quitman, Lafayette, Tallahatchie, Bolivar, Grenada, Leflore, Montgomery, Sunflower, Carroll, Washington, Humphreys, Holmes,

	Delta Health Alliance (DHA) Grants:	Attala, Sharkey, Yazoo, Issaquena, Madison, Warren, Covington, Forrest, Lamar, Perry, and Pear River). a. Improving Health Care b. Increasing Health Information Technology c. Expanding Educational Opportunities d. Helping Families e. Building Promise Communities
	Agenda Topics	**Agenda Notes**
	Delta Health Alliance (DHA) Grants:	• Ms. Sha'Ketta Davis, Director of Mental and Behavioral Health at Delta Health Alliance presented an extremely informative presentation on the following: Delta Health Alliance (DHA) Grants: a. DOT Initiative - Delta Opioid Taskforce 1 1. Created a comprehensive channel of services that addresses the opioid epidemic in the rural MS delta. b. Delta Opioid Taskforce 2 1. Developed a sustainability plan focusing on the treatment and recovery of opioid use disorder. c. Delta STAR - Systems of Treatment and Rehabilitation 1. Individuals 8 years or older, abusing alcohol and desiring a fresh start in life. d. Deer Creek Behavioral Health Network 1. Utilize inpatient therapists and teletherapy to prove assess to treatment for a co-occurring disorder. In conclusion, Ms. Sha'Ketta Davis stated, we as a culture consistently wanting immediate pain relief should not go to opioids as the first choice. If a doctor advises a patient to take all pain prescribed meds, be extra careful, the pain maybe gone without

		taking all of the medication. Other forms of relief are: a. Equine Therapy b. Meditation Therapy c. Swimming/water aerobics d. Walking e. Reading f. Cycling g. Stretching (Yoga)
	Agenda Topics	**Agenda Notes**
(8)	**Permanent (Past/Present) Memorial:**	• Mr. Greg Bufkin, Executive Director, El Roi Ministries, presented a most innovative idea for a structured memorial. At present there are 2 phases to this project, Mr. Bufkin summarized in a memo the following: a. First, the organization is in the process of building a memorial for people who have died in addiction, as well as those walking in recovery. It will be the first permanent memorial of its kind in the nation. The memorial will be located just south of the interstate, off the east end of Stenum Road, in St. Martin, where a piece of land worth approximately $40,000 has been donated for the memorial. The memorial will be able to be seen from the interstate. b. There will be a sculpture at the center of a seated, featureless man, with a large hole through his chest. The hole represents the emptiness the addict is always trying to fill, unsuccessfully. It also represents the emptiness the family feels when a loved one dies in their addiction. c. The sculpture will have engraved brick pavers on the ground behind it, and in front of it. Behind the sculpture will be bricks engraved with the names of people who died in their addiction, as well as the dates they died. In front of the sculpture will be bricks engraved

		with the names of people walking in recovery, and the dates they began their recovery. The memorial will show the reality of addiction, while also offering hope. d. There will be two benches in front of the sculpture where families can sit and work through their grief, have empty chair conversations, or simply remember their loved one. e. Once completed, Roger Wicker's office will be asked to petition congress to officially recognize The National Overdose/Recovery Memorial as the nation's official memorial on recovery. f. The goal is to raise most of the money through sponsorships, so the price points of the bricks can be lowered as much as possible. This will enable more families to participate.
	Agenda Topics	**Agenda Notes**
	Permanent (Past/Present) Memorial:	g. Second, on September 14th, in Ocean Springs, MS there will be an annual '*Rally for Recovery*.' As part of Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Recovery Month, mental health and addiction programs from across the nation will be brought together to network and provide information to the public about resources available for treating mental health and addiction issues. Last year there were 61 programs from 6 different states represented at the Rally. This year there are presently 10 different states committed to attend. There are programs from as far away as South Dakota, New Jersey, and Pennsylvania.
(9)		• Mr. Dwight Owens, Motivational Speaker, American with Disabilities Act Consultant, and a renowned published author of the book "*Still Standing*" presented an account of real-life challenges: a. This was a riveting presentation with a powerpoint that captured an array of memorable life events. Showing the true character of a survivor, Mr. Owens, adamantly contented, one must face the challenge of acceptance, treatment and healing head on, establishing a positive mind-set and using new tools for recovery.

	Still Standing:	b. Ultimately refusing to be limited by boundaries, Mr. Owens, brings faith and perseverance together in his work, creating a literary voice that speaks to and of human greatness. He is a writer to be treasured, respected and definitely imitated. c. Active in alcohol and drug prevention around the state, including numerous schools, Mr. Owens is referred to as the *beast*! He wears the term proudly because of his spectacular and extraordinary zest for life. Mr. Owens stated, "It's very important to me that my life is used to impact as many as possible while I still can." d. Mr. Owens' guiding principles of behavior: We all must be the best that we can be, sometimes our lives have been turned upside down because of:
	Agenda Topics	**Agenda Notes**
	Still Standing:	1. Alcohol and drugs 2. Murder 3. Betrayal 4. Death/suicide 5. A disability 6. Thinking only about self 7. No self-awareness 8. Bullying 9. Anger 10. Violence/domestic 11. Alienation 12. Loneliness

		e. Receiving a standing ovation, Mr. Dwight Owens concluded the presentation with these words, *"there is no dis in my ability!"*
(10)	**Bureau Director's Corner:**	• Mr. Charles Oliphant, Director, Division of Wellness and Recovery Supports, Bureau of Behavioral Health/Addictive Services gave an informative update on the following: a. 2019 Opioid & Heroin Drug Summit: Wednesday, July 24, 2019 at 1:00 PM - Friday, July 26, 2019 at 10:00 PM (CDT) Broadmoor Baptist Church, 1531 Highland Colony Parkway, Madison 39110 b. The MS Department of Mental Health's Efforts to Address the Opioid Crisis: 1. David Trewolla, JR 2. Mae Slay
Agenda Topics		**Agenda Notes**
	Bureau Director's Corner:	c. The SAMHSA OTP Information Center Renewal/Re-certification for online SMA-162 processing system, with SAMHSA OTP Information Center at 1-866-348-5741, or via email at OTP-Help@jbsinternational.com d. Stand Up Mississippi is a partnership with the Department of Mental Health and 6 additional agencies that provide training to law enforcement officers to use naloxone. Naloxone is a medication that reverses the effects of an opioid overdose. The Coordinator of Stand-Up Mississippi is: 1. Mae Slay e. The Funding Continuation Application for: 1. Prevention Services 2. Outpatient Services 3. Residential Services

Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

Meeting Minutes

(11)	**Chairperson's Corner:**	• Mr. Grist asked the council members for announcements, concerns or questions about *old business* or *new business*. a. Announcements: 1. Ms. Jody Dorman, Choctaw Behavioral Health a. The Annual Choctaw Indian Fair will be July 8-11, 2019. A celebration of heritage and culture. The meeting was adjourned as Mr. Grist told the council to *have a good day and drive safely!*
(12)	**Adjournment:**	• The meeting was adjourned by the Chairperson, Mr. Joe Grist at 3:03 p.m.
	Agenda Topics	**Agenda Notes**
	Agenda Items Proposed for Next Meeting, Thursday, October 11, 2019	
(13)	**The FY 2020-2021 State Plan (Draft):**	**Additional Information:** • The MS Department of Mental Health, Bureau of Behavioral Health/Addictive Services has drafted its 2020-2021 State Plan, as required by the Substance Abuse Mental Health Services Administration (SAMHSA) for continuous Substance Abuse Block Grant (SABG) funding. • The *State Plan (Draft)* will be released for public comment and uploaded on the Department of Mental Health (DMH) and the Secretary of State's website. • The *State Plan (Draft)* will be released to council members no later than August 30, 2019 • Approval is needed from advisory members by September 30, 2019
• To have a topic placed on the agenda, please contact the MS Department of Mental Health, Bureau of Behavioral		

Meeting Minutes

Health/Addictive Services Advisory Council Chair or Vice-Chair at least three weeks before the next meeting:	
BBH/AS Advisory Council Chair: Mr. Joe Grist North MS State Hospital 1937 Briar Ridge Road Tupelo, MS 38804 662-690-4200 662-321-0059 E-mail: joe_grist@nmsh.state.ms.us	BBH/AS Advisory Council Vice-Chair: Dr. Shawn Clark Veterans Administration 5234 Parkway Drive Jackson, MS 39211 601-957-6746 601- 362-4471 (6192) E-mail: shawn.clark@va.gov

~Notes~

Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

Meeting Minutes

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Mark Cheney	Others (Advocates who are not State employees or providers)	MS A&D Advisory Council	7070 Highway 80 Vicksburg MS, 39180 PH: 601-638-4784	
Shawn Clark	Providers	V A Medical Center	1500 E. Woodrow Wilson Avenue Jackson MS, 39216 PH: 601-362-4471	shawn.clark@va.gov
Amanda Clement	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	614 Eatonville Road Hattiesburg MS, 39401 PH: 601-297-7014	aclement123@gmail.com
David Connell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Behavioral Health Advisory Council Chair/Contact	44 Bates Lane Hattiesburg MS, 39402 PH: 601-520-1096	barbaque2004@yahoo.com
Chelsea Crittle	Providers	Central MS Planning and Development District	1170 Lakeland Drive Jackson MS, 39296 PH: 601-981-1516	ccrittle@cmpdd.org
Andrew Day	State Employees	Division of Medicaid	550 High Street Jackson MS, 39201 PH: 601-359-6114	andrew.day@medicaid.ms.gov
Kay Denault	Providers	The Mental Health Association of South Mississippi	4803 Harrison Circle Gulfport MS, 39507 PH: 228-864-6274	kay@msmentalhealth.org
Margaret Ellmer	State Employees	MS Department of Education	359 N.West Street Jackson MS, 39201 PH: 601-359-3498	margaret.ellmer@mdek12.org
Annette Geinesser	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self; Long Range Planning Committee	238 Sawbridge Drive Ridgeland MS, 39157 PH: 601-853-0815	bgeorgeg@att.net
Maxie Gordon	Providers	MS Psychiatric Association	University of MS Medical Center Jackson MS, 39216 PH: 601-984-1000	maxiegordon@bellsouth.net

Lavonda Hart	State Employees	MS Department of Rehabilitation Services	P.O. Box 1698 Jackson MS, 39215 PH: 601-853-5270	lhart@mdrs.ms.gov
Ronney Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	V A Medical Center	211 Samuel Road Madison MS, 39110	ronney.henderson@va.gov
Jamie Himes	Providers	Southern Christian Services for Children and Youth	860 E. River Place Jackson MS, 39202 PH: 601-354-0983	scscyjamie@att.net
Jessica James	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self	791 W. County Line Road Jackson MS, 39213 PH: 601-454-0507	jesspraise37@outlook.com
Joe Kinnan	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Mississippi - Pine Belt Affiliate	204 Greenwood Place Hattiesburg MS, 39402 PH: 601-264-6994	jekin@comcase.net
Sandy Kinnan	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Mississippi - Pine Belt Affiliate	204 Greenwood Place Hattiesburg MS, 39402 PH: 601-264-6994	jekin@comcast.net
Toniya Lay	Representatives from Federally Recognized Tribes	MS Band of Choctaw Indians	210 Hospital Circle Choctaw MS, 39350 PH: 601-390-6291	toniya.lay@choctaw.org
Janette McCoy	State Employees	Institutions of Higher Learning	3825 Ridgewood Road Jackson MS, 39211 PH: 601-432-6486	jmccrory@ihl.state.ms.us
Ben Mokry	State Employees	MS Home Corperation	725 Riverside Drive Jackson MS, 39202 PH: 601-718-4611	ben.mokry@mshc.com
Judy Newton	State Employees	MS Insurance Department	P.O. Box 79 Jackson MS, 39205 PH: 601-359-1203	judy.newton@mid.ms.gov
Ekoko Onema	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	111 Woodward Court Jackson MS, 39212 PH: 980-210-0722	ekokomonique@gmail.com
Elaine Owens	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	105 Garden View Drive Brandon MS, 39047 PH: 601-407-4783	jeco0650@gmail.com
Coreaner Price	Parents of children with SED/SUD	Families As Allies	840 E. River Place Jackson MS, 39202 PH: 601-355-0915	cprice@faams.org
Kim Richardson	State Employees	MS Bureau of Investigation	2200A Highway 35 N Batesville MS, 38606 PH: 662-563-6477	krichardson@dps.ms.gov
Tara Roberts	Parents of children with SED/SUD	Families As Allies	840 E. River Place Jackson MS, 39202 PH: 601-355-0915	tmanning@faams.org
Tonya Tate	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	152 Edward Owens Drive Terry MS, 39170 PH: 601-954-2421	ttate@bellsouth.net

Wanda Thomas	Providers	Catholic Charities, Inc.	850 E. River Place Jackson MS, 39202 PH: 601-355-8634	wanda.thomas@ccjackson.org
Tameka Tobias	Others (Advocates who are not State employees or providers)	NAMI MS	2618 Southerland Street Jackson MS, 39216 PH: 601-899-9058	tsmith@namims.org
Larry Waller	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	11085 Old Dekalb Scooba Road Scooba MS, 39385 PH: 662-476-8035	tlwaller@bellsouth.net
Nancy White	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	332 Becker Street Brookhaven MS, 39601 PH: 423-331-1243	godbold52@att.net
Harold White	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Self	332 Becker Street Brookhaven MS, 39601 PH: 423-331-1243	hwhite52@att.net
Mark Williamson	State Employees	MS Department of Human Services	750 N. State Street Jackson MS, 39201 PH: 601-359-4500	mark.williamson@mdhs.ms.gov
Scott Willoughby	Providers	South Mississippi State Hospital	823 Highway 589 Purvis MS, 39475 PH: 601-794-0241	swilloughby@smsh.state.ms.us
Melody Worsham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	AMPSS	6474 Florence Road Biloxi MS, 39523 PH: 228-864-6274	melody@msmentalhealth.org

*Council members should be listed only once by type of membership and Agency/organization represented.
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
This is not inclusive of the SA Advisory Council Members. The MHBG Coordinator created a joint application in error.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**34**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	9	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**19**	**55.88%**
State Employees	8	
Providers	7	
Vacancies	0	
Total State Employees & Providers	**15**	**44.12%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**11**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
This is not inclusive of the SA Advisory Council Members. The MHBG Coordinator created a joint application in error.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

SABG

The URL links for the final copy of the FY 2020-2022 Behavioral Health/Addictive Services State Plan is available for review on the Secretary of State website as well as the Mississippi Department of Mental Health website below:

https://www.sos.ms.gov/adminsearch/ACProposed/00024575b.pdf

http://www.dmh.ms.gov/wp-content/uploads/2019/09/2020-2022-DMH-BBH-AS-State-Plan-for-Sec.-of-State-No-Mark-Up.pdf

MHBG

The following email was released on August 12, 2019, by The Bureau of Outreach and Planning at the Mississippi Department of Mental Health: The Draft FY 2020-2021 Mental Health Block Grant Application/Mississippi State Plan for Community Mental Health Services is available for review on the Mississippi Department of Mental Health's website. The document has been placed on the Resource Library page of the site found at www.dmh.ms.gov/resources/ under the section labeled Community Mental Health Services Documents. The public comment period for the Plan is August 12, 2019, through August 30, 2019. All comments and questions are welcome and may be addressed to Lynda Stewart via email at lynda.stewart@dmh.ms.gov or by telephone at 601.359.6263. A copy of the plan is also attached to this email. Thank you.

URL: www.dmh.ms.gov/resources/

The MHBG Application/Plan received comments from three entities, two of which are represented on the Advisory Council. All comments were received on the final day of the public comment period.

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

This Section is not inclusive of SA's State Plan and Public Comment Release information. The MHBG Coordinator created a Joint MH and SA Block Grant Application in error. The SA Coordinator will provide an update by October 1, 2019.